Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ DREDDEN URTIS 4:14 サンレン 2010 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1 M 2 □ F 9 (Month, Day, Hours Min. Director ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. That if if item 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examinar must be notified at lury or other traumatic event, the Medical Examinar must be notified at 10a, State **Funeral Director** 1 Yes 2 No MOY 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dorey ttress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည (Sister) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Livensee Ho m 21216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Respiratory Distress Physician Medical Due to (or as a consequence of): Examiner AIDS-HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hour after death.

To the 24 hour after death.

To the 24 hours Director After this certificate has been signed by the attending physician and completed files in by the funeral director, page 2 should be detached for use as the bunal-transit topenia Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical GENERE BEDGIS P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ٩ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 X Natural 5 🗆 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RESIDENT RES-000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S Hanover st 21225 Baltimore AHMED 31. Date filed (Month, Day, Year) State 5 Registrar

DHMH 17 Rev 7/2009

10-05227 Joseph Daniels Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Joseph Daniels		I- For State	state of Maryla		artment of		Mental I		Reg. No	201	0	22002
Physicia		Registrar 1. Decedent's Name (First, Mid	dle,Last)					2. Date of De	ath		- <u>"</u>	3. Time of Death
Medical Examin		Joseph W.	Daniele					July 12, 2	Day 2010	Year		1745 hrs
		4a. Facility Name (if not institut		umber)		4b. City, Town, or L	ocation of Dea			c. County of	Death	
A.		Johns Hopkins Hosp	ital			Baltimore			!	n	/a	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24h	Irs. 8. Date of B	irth(MM	/DD/YYYY)	9. Birt	nplace (State or
Director	-	100 70 1000	1 X M 2 F	1.1	Yrs	Months Days	Hours M	lin.	1 /	1998	Foreig Cou	i ^{ntry)} PA
	H	183-78-1883 Usual Residence of Decedent		11		1 1		NOV	149	1990]		IA
au k	ŀ	10a. State 10b. Count	/	10c. City	, Town or Locat	ion						10d. Inside City Limits
d .e. d		D 4 V-	1-	9	Vorl							1 Yes 2 X No
rylan 8-f st	홟	PA Yo 10e, Street and Number	rk		York	10f. Zip Code			10g. Cit	tizen of What	t Coun	try?
ne Maryland or 28a-f show any fied at once.	Director		_					:		71.0		
23a notif		148 Sylvan Dr		cedent Ever in L	ie 12 W	Is Decedent of Hisp	402	Specify Ves or N	0	US.		can Indian, Black,
ath w	Funeral	TT	Married Armed F	orces?		es, specify Cuban,			•	White,		arrivating bloom,
er der , or i	리	3 Widowed 4 D	1 Yes ivorced If Yes, Give Yes	2 X No		Yes 2X No	snecify:			Specify:	т	11 - 01-
rs aft ural"	ᅪ	15. Decedent's Education (Sp	or Dates:		16a Deceder	it's Usual Occupation		of work done	16b.	Kind of Busin		Black
hou.	ompleted	Elementary/Secondary (0-12	etired)				,					
36 un 72 un	휣				Crad	2 م	choo1					
With With Brench	틝	05 n/a Student 17. Father's Name (First, Middle, Last) 18.Mother's Name									2 3	CHOOL
15.				Tan			Debra			send		
	A P	John B. 19a. Informant's Name/Relation	Daniels,	JI.	19b. Mailin	Address (Street					State,	Zip Code)
shot and its	-1	Debra K. & Joh		1c/Pare	100	48 Sylvai				1740	_	
and 2 and 2 ealth tem 2 trau		20a. Method of Disposition	ii b. Danie			ition (Name of cem		Date		Location - C		Town, State
Or H		1 X Burial 2 Cremati	on 3 Removal fr		crematory or ot						_	
Pag ment tant		4 Donation 5 Other		Pr		Hill Ceme		7/17/10		York	, P	A
Balt permit. Departi Import	t	21 Signature of Funeral Service	Cosee .		22. N	Name and Address	of Facility eral Ho	ome of D	ular	nev Va	11e	v Inc.
	1	Bryan W. Clar			110	mmon Fundo	nia Roa	id, Timo	niun	n, MD	210	
Physician /M di I		23a. art I. En er the disease, of failure. List only one caus		caused the death	n. Do not enter t	ne mode of dying, s	such as cardiae	c or respiratory ai	rest, sn	lock, or near		Approximate Interval Between Onset and
Examiner	ı	Imme In Cause (Final disease	e a Moad and	chest injurie	s							Death
,£	- 1	or condition resulting in death)	Due to (or as a	a consequence of	of):							
	اي	Sequentially list conditions,	b.	a consequence o	of):				_			
	Examiner	if any, leading to immediate cause. Enter Underlying Caus	e	a consequence (01).							
	É	(Disease or injury that initiated events resulting in death) Last		a consequence o	OT):							
cuted	빞		d									
be executed sician and urial - transi	dical	UNPENDED	AMENDED									
	യ⊩	IF FEMALE:	23c. If yes,	outcome of pres	gnancy				23	3d. Date of de	elivery	
587 artific ling p	ਗ	23b. Was decedent pregnant in past 12 months?	I . Trive !			tal death 3	Ectopic preg	nancy		Month	D	ay Year
ath ce attence or use	Sici	1 Yes 2 No 9 U		nant at time of d	eath 5 Ot	her (Specify)			- 1			
he de hed f	ᇍ	Part II. Other significant cond	9 011111	_	roculting in the	underlying cause gi	uon in Part I	23a Did	tobacco	use contribu	ite to	he cause of death?
Division of Vital Records, P.O. Box 6876. rial or Attending Physician: The law requires that the death certificate rs after death. "al Director: After this certificate has been signed by the attending phylic in by the funeral director, page 2 should be detached for use as the l	þ	Part II. Other significant cond	itions contributing t	o death but not	resulting in the t	ariderlying cause gr	veri il i art i.				_	ably 4 Unknown
S, F uires												
cords law requi	<u>ğ</u>							24a. Was	psy	prie	or to c	opsy findings available ompletion of cause of
ecc he lar ute ha	Completed							perf 1 ✓ Yes	ormed?		ath?	s 2 No
tal Recian: The	ပ္ခဲြ	25. Was case referred to medic	cal			26.Place	of Death (Chec	ck only one)				
Vita hysicia this ce	Ö	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other Nur	sing Home 5	Resid	ence 6	Other	
n of \ing Phy After th	-	27. Manner of Death	28a. Date	of Injury	28b. Time of	njury 28c. Injury	at Work?	28d. Describe				
andiin A	Certification:		nding Jul 3, 2	h Day,Year) 010	1500 hrs	1 Y	es 2 🗸 No	Jet ski jet s	ski col	lision		
isior Attend er death. rector:	<u>[g</u>		estigation 28e. Plac	ce of Injury - At h	nome, farm, stre	et, factory, office bu	ilding, etc.				or Ru	al Route Number, City
Ts aft of Is aft in Is aft	틹		uld not be (Specify)	Creek				or Town, Irish Creek,	State) Royal (Oak, MD		
fospi 4 hou vuner	<u>٥</u>	29a. Certifier	Physician: To the be		dge death occu	rred at the time dat	e and place, a	1			s state	d.
Division of Vital Records, P.O. Box 68766 within 24 hours after death. The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	edical	Check only	caminer:On the basis	of examination								
To To con	Med	29b. Signeture and title of certi	and manner s			29c. License						th, Day, Year)
	-	6/111	110	1	7	O.C.N				y 13, 201		
16		avvi	101		V4			<u> </u>		, ,		
101		30. Name and address of person				n Stroot Ballin	more MD 1	21201				
		Zabiullah Ali, M.D.	Assistant Medic	_		n Street, Baltir	noie, MD 2	-1201				
Sta Registr		31. Date filed (Month, Day, Yea	1 5 2010 32. R	egittrar's Signat	ture	barked						

10-05164 Virgil Dinkel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Virgil Dinkel		I- For State	Sta	ite of Maryla	-	artment o		id Menta	ıl Hyg		an Na G	201	0 2	2003
Physicia Medical Examin	n/	Registrar 1 Decedent's Name Virgil	(First, Middle	,Last)		Dinkel				Date of Dea Month	th Day	Year	3. Time o	f Death
		4a. Facility Name (if		, give street and nu			4b. City, Town, or			July 10, 20	4c. Coi	unty of Dea	th	1113
Funeral		7923 Roxbur 5. Social Security Nu	•	3. Sex	7. Age (In yrs. I	ast birthday)	Glen Burnie		24Hrs. [8	B. Date of Bir		Arunde		ate or Foreign
Director		514-40-30		1XM 2 F		0 Yrs	Months Day		Min.		, 193	C	ountry)	
any	- 1-	Usual Residence of I	Decedent Ob. County		Inc. City	Town or Local	ion						10d Insid	de City Limits
*	٦	MD	Anne A	Arunde1	100.00	Glen I								es 2 X No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Num					10f. Zip Code			1	0g. Citizen o	of What Co	untry?	
with the	ם	7923 Roz	kbury I		edent Ever in U	.S. 13. Wa	21061 as Decedent of His	spanic Origin	? (Speci		U.S.A		rican Indian	. Black.
death v	Funeral	1 Never Married	_	1 X Yes	2 No		es, specify Cubar					White, etc.		
urs after tural",	ል.	3 X Widowed 15. Decedent's Edu		rced If Yes, Give Yea or Dates: fy only highest grad		16a. Deceder	Yes 2X No nt's Usual Occupa	tion (Give kin	d of work	k done	Spe 16b. Kind	cify: W	hite /Industry	50A
15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last)							ost of working life						·	
ed withi	<u>ا</u>	17. Father's Name (F	irst, Middle, L	_ast)		Maste	r Sergea	18.Mother's I		,	1	Army name)		
21215-0036 suld be filed within 72 Mental Hygiene. marked other than cevent, the Medical	Be	Peter A. 19a. Informant's Nam				40h Mailia	g Address (Stre		-	y Habe				
and 2 shou ten 27 is n	^[erd/Frien	d		Falls F							,
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland lent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispo 1 X Burial 2	-	3 Removal fr	L L	Place of Dispos crematory or ot	sition (Name of ce her place)	metery,	July	16,	20c. Loca	tion - City o	r Town, Sta	:е
	-	4 Donation 5 21. Signal major Fund			Ma		Vets. Ce lame and Addres		201	_			le, MI	
Balti permit. Departr Importr injury o		10/1	1/		M0122	o Se	rvices E	PA 1 2r	id Av	ve. SW	Glen	Burn		
Physician Medical		23a. Part I. Enter the failure. List only	one cause o	omplications that can n each line. a. Atherosclei				, such as card	diac or re	spiratory arr	est, shock, d	or heart	Betwee	mate Interval n Onset and Death
aminer		Immediate Cause (F or condition resulting			consequence of		ease							
	Jer	Sequentially list conditions, leading to imm	nediate	b. Due to (or as a	consequence o	of):				_			+	
	Examiner	cause. Enter Underl (Disease or injury the events resulting in de	at initiated	c. Due to (or as a	consequence o	f);	••••							
	edical E	UNPENDED		d. AMENDED				-						
760, cate be exphysician the burial		IF FEMALE:	range and in the	23c. If yes,	outcome of preg	nancy	· · ·				23d. Da	te of delive	ry	
Box 6876 death certificate the attending phy ed for use as the t	ician	23b. Was decedent p past 12 months?		4 Pregn	irth ant at time of de		tal death 3 her (Specify)	Ectopic p	regnancy	′	Mor	ith	Day	Year
b. Boy the death	Physician/N	1 Yes 2 No		9 Unkno				niven in Part	1	23e Did to	nhacco use		the cause	of death?
si s	ھ	Diabetes me				g		9			_		obably 4	
tal Records cian: The law requi	Completed									24a. Was autop			completion	ngs available of cause of
Vital Rec		25. Was case referre	d to medical				26 Place	e of Death (Cl	hook only	1 Yes	2 ✓ No			2 No
25. Was case referred to medical examiner? A property of the								Othor:			Residence	6 🗸 Oth	er: Scene	
ading P ading P th. : After e funera	uo O	 Manner of Death Matural 	5 Pendir		of Injury Day,Year)	28b. Time of I		iry at Work? Yes 2 N		d. Describe l	how injury o	ccurred		
Division of pital or Attending Plous after death.	Certification:	2 Accident 3 Suicide	Investi	gation 28e Plac	e of Injury - At h	ome, farm, stre	et, factory, office t					lumber or F	ural Route I	Number, City
Ospital hours a uneral l		4 Homicide	determ	(0,000.))						or Town, S				
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only		rsician: To the besiner: On the basis of and manner s	of examination a	-								
	Ž	29b. Signature and ti	tle of certifier	11000) .		29c. Licens						onth, Day, Y	ear)
15/1	-	30. Name and addres	ss of person w	no completed caus	e of death (Item	1 23a)	O.C.	IVI. L.			July 13	, 2010		
1 "		Carol Allan, I	MD Assi	stant Medical	Examiner	111 Penn	Street, Baltim	ore, MD 2	1201					
Sta Registr	ite ar	31. Date filed (Menta	2010	Den 32. Re	gistran Signa	PONTO								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 22004 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death July 14, 2010 Physician/ William Pompelle Fink 3:32P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Center If Under 1 Year If Under 24 Hrs Social Security Numbe Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🙀 M 2 🗆 F Days Hours Months January 2, 1945 Mary and 65 Director 214-46-9129 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 11114 Greenspring Avenue hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married à Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Vos Give Specify: 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) the Real Estate Realtor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked or raumatic ever Emilie Cochran Cannon William Louis Fink permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11114 Greenspring Avenue Lutherville, Maryland 21093 Wife Nancy Bartholomew Fink Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ី Cremation 3 ☐ Removal from State GreenMount Crematory Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) July 19,2010 nature of Funeral Servi 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Çnysician/ 101 disease or condition Medical resulting in death) Examiner mocardia Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No Unknown 9 Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Hospital or Attending Physician: The law requires that within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ 2 ⊅No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010

State Registrar MRON

31. Date filed (Month, Day, Year)

alle

W

TUNSON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

32. Registrar's Signature

For State					te of	Maryla				ealth and I	Mental Hy	giene	2010	22005
			Registrar 1. Decedent's Name (First, Middle	Last)			Cer	tificat	te of D	eath	Tab. (5)	Reg. No	2010	
	Physicia Medic		WILLIA	M			-USS	ELL			2. Date of De	29	2010	3. Time of Death 2:15 AM
	Examin	er	4a. Facility Name (if not institution) FOREST HAVE		RSIN		ME	CA	TONS			13	County of Deat	
	Funeral Director		5. Social Security Number 220-14-7231	6. Sex 1 K M 2	T F	Age (In yrs. 84	last birthday) Yrs.	If Unde Months	Days	Hours Min.	8. Date of Bir (Month, Da AUGUST	th 3, ^{Year)} 3, 19	9. Bird Co. NOR	thplace (State or Foreign untry) TH CAROLINA
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County			10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	e Maryla r 28a-f s notified	Director		N/A				405 7	- Oada	BALTIN	MORE			1¥☐ Yes 2 ☐ No
	vith th	ral	10e. Street and Number 701 EDMONDSON	AVENUE				101. 2.1	p Code 212	201		10g, Citi	zen of What Co USA	ountry?
	eath v tems er mu	Funeral	11. Marital Status	12. Was		nt Ever in U	J.S. 13.\	Vas Dece	dent of His	spanic Origin? (Sp	ecify Yes or No-	. T	14. Race - Ame	
920	o fled within 72 hours after death with the Maryland tal Hygiene. And other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	ρ	1 Never Married 2 Marria 3 Divorced	ried 1 X If Ye	ed Force Yes 2 s, Give r or Dates	☐ No			2 X] No	Specify:	Hican, etc.)		Black, White Specify: BL	
2-0	15. Decedent's Education 16a. Decedent (Give kind (Give kind							lent's Usu	ual Occupa	ition uring most of work	kina	16b. Ki	nd of Business	Industry
121	ithin 7; ene. r than the Me	Completed	Elementary/Seconday (0-12)		ege (1-4 o	or 5+)	life. Di	NOT us ERK	e retired)	g	9	IIS	POSTAL.	SERVICE
Maryland 21215-0036	ould be filed wit d Mental Hygie marked other matic event, th	To Be	17. Father's Name (First, Middle, L	,	<u> </u>		1 02	ШКК		18. Mother's Nan	ne (First, Middle,			DERVIOE
aryla	1 and 2 should be of Health and Men item 27 is marke other traumatic		WILLIAM J. FU	-			19b Mailir	a Addres	es (Stroot a	nAOM1 on Number or Rui		ar City or	Town State Zin	
	and 2 sh Health ar tem 27 is ther trau		J. MICHAEL HOL	LOWAY-	GUAR OF P	DLAN ROPER		-		RT STREET				
altimore,			20a. Method of Disposition 1 X Burial 2 Cremation	3 ☐ Remova	ıl from Sta		Place of Dispo cemetery, cren			1	Date		cation - City or	Town, State
<u>=</u>	Pag ant:		4 ☐ Donation 5 ☐ Other (S 21. Stonature of Funeral Service L			GA	RDENS C			7/1 s of Facility MII	16/2010			MARYLAND
Ba	permit. Departr Imports any Inji	8 9	21. Stratule of Pulleral Service L	- Cerisee						R ROAD I				
ı			23a, Part 1 Enter the distase, or shock, or hear failure. List of	complications nly one cause	that cau	sed the dea	ath. Do not ente	er the mod	de of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
- {	'ny sician Medical	i	Immediate Cause (Final disease or condition resulting in death)	a	ua ta (ar		Vasa	Nor	1	ements 4				Onset and Death
	Examiner				ue to (or a	as a conse	quence on:							
_	sit sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impry	D	ue to (or a	as a conse	quence of):							
	ate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. D	ue to (or a	as a conse	quence of):							
09	ate be e ohysicia the bur	dical		d										
687	ertifica iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If ye	es, outcor	ne of pregr	nancy					1.	23d. Date of de	livon
	requires that the death certificate be executed be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 🗆		nt at time of	tal death 3 [f death 5 [Ectopic Other (s	pregnancy specify)	/			Month Month	Day Year
P.O.	law requires that the has been signed by the e 2 should be detach	y Phy	Part II. Other significant condition	ns contributin	g to deat	h but not re	esulting in the u	nderlying	cause give	en in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
ds,	quires t en sign uld be	ed by									1 🗆	Yes 2[□No 3□P	robabiy 4 Onknown
COL	law rec has bee e 2 sho	Completed									24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
¥	in: The ificate or, pag		25. Was case referred to medical						26 Pla	ce of Death (Chec	1 🗌 Yes	2 No		3 2 No
\ Kalendari	ysicia Is cert direct	To Be	examiner?	Hospital:	1 🗆 Inp	atient 2	☐ ER/Outpatier	t 3 □ E	Othe		ome 5 Resi	dence 6	Other (Spec	ify)
n ot	ding Ph h. After th funeral	:ate:	27. Manner of Death 1 → Natural 5 → Pendin	g	Date of i (Month,	njury Day, Year)	28b. Time of injury	м	28c. Injury work?	at	28d. Describe			
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s	Certificate:	2 ☐ Accident Investic 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e.		Injury - At I	nome, farm, stre			res Z 🗆 NO	28f. Location (City or To			ral Route Number,
ם מ	spital o		29a. Certifier 1 Certifying	Physician: To	the best	of my know	wledge, death o	occured a	t the time.	date and place, a				ated.
)	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check	xaminer: On t Nurse Practi	he basis o	of examinati	on and/or invest	igation, in leath occu	my opinior urred at the	n, death occurred a time, date and pla	at the time, date	and place,	and due to the	cause(s) and manner stated.
	North		29b. Signature and title of certifier		00.0				c. License			29d. Dat	e signed (Monti	h, Day, Year)
	+1.		30. Name and address of person v	who completed		of death (Ite	m 23a) (Type, F		J 7 1	707			1 1110	
1			Ray non Mille 31. Date filed (Month, Day, Year)	283		Smith	Acc 5	nite	203	Ball	we my	2	1209	
	Stat Registra		31. Date filed (Month, Day, Year)	2010	32 legis	strar's Sign	A. A.	file	225					

	1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2010 2200											06					
	Dhusisis	-/	1. Decedent's Name	e (First, Middle, L	ast)							2. Date of De	ath			3. Time of	Death
8	Physicia Medic		Stavroul									Month JULY	9	ay 20	10	7:11	РМ
	Examin	er	4a. Facility Name (if					4b. City,	Town, or L	Location o	of Death			c. County o		_	
	Funeral		GREATER 5. Social Security No	BALTI	Cov		CENTE a. last birthday)	R If Under	TOWS	SON If Under	24 Hrs.	8. Date of Bir		BALTI		lace (State o	r Foreian
	Director		200-46-17	712	1 M 2 K	57	Yrs.	Months	Days	Hours	Min. J	ully 30	, ¹ 19	52	Gree		i i oreign
-	d t t		Usual Residence of 10a. State	Decedent 10b. County		10- /	Situ Taura and a										
	arylan a-f sh fied a	Director	Md.	Balt	0	100.1	City, Town or Loc	gsvil	10						11	0d. Inside Ci	2 🕅 No
	or 28	[출	10e. Street and Nun		.0.			10f. Zip					10a C	itizen of Wh	at Coun		2 22 140
L	with 1 s 23a ust b	Funeral	7309 Long	gfield D	rive			21	087					Greec		.,,	
2	death item		11. Marital Status	_v	A 1 F .	edent Ever in l		Vas Deced	ent of Hisp	panic Orig	gin? (Speci	fy Yes or No-		14. Race -			
38	after ", or xamii	a P	1 Never Marri		1 ☐ Yes If Yes, Giv	ve ² X No		☐ Yes 2	_			33.1, 3.0.,		Specify:	White, e	nc. hite	
> §	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by		15. Decedent's			16a. Deced	lent's Usua	Occupat	tion			16b l	Kind of Busi			
TAVROUL, 1215-0036	in 72 e. nan "ı		(Spe Elementary/Seco 6 t h		grade completed College (1		life. DO	kind of worl O NOT use	retired)	ıring most	t of working	7	100.1			uotry	
N (V	d within lygiene. lher tha nt, the f	l ou l					Home	maker						Hom	e 		
K15. Maryland	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (F		,							First, Middle, Panag		,			
S1.S aryla	2 should be th and Men 27 is marke traumatic		19a. Informant's Na				19b Mailin	a Address	(Street an			Route Numbe			to Zin C	ada)	-
		H	Peter For	•	, , , ,	Son						Hall,				oue)	
Specific	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th		20a. Method of Disp		Removal from		. Place of Disport)	Da	te	20c. L	_ocation - C	ity or To	wn, State	
Ei C	permit, Page Department of Important: If any injury or once,			5 Other (Spe		Oa	klawn C	emete	ry	7	-14-2			timor		d.	
Balti	permit. Departr Importa any inju		21. Signature of Fur	neral Service Lice	ensee	(0	22					munek				2122	
			23a. Part 1. Enter th)	molications that	caused the de	ath. Do not ente					respiratory an		gnam,	Ma.		
	Ph, sician/		shock, or hear Immediate Cause (I	rt failure. List only Final	one cause on ea	ach line.	100.00	L 10	or dying,	-Carri	1	copilatory an	,			Approximat Interval Bet Onset and I	ween
	Medical		disease or condition resulting in death)	n 🔏	a. Due to	(or se a conse	quence of):	rea	/ L .	JON	<i>IW</i>	2			-	1 mg	YVIN
	Examiner		Sequentially list cor	nditions	b-Po	will	e pu	lmo	nar	y e	m6	oli or	1	NI			
	p #	nine	if any, leading to im cause. Enter Under	mediate rlying	Due to	(or as a conse	queno of):			(
	icate be executed g physician and is the burial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) L	3	c. Due to	(or as a conse	quence of):										
0	be ex sician buria	dical	,		d		,										
3760	certificate nding physuse as the		IS =50.441 5		d												
Box 687	h certi endin r use	an/l	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out	tcome of preg	nancy etal death 3	Ectopic p	eanancv					23d. Date	of delive	ry	
Bo	deat the att	Physician/M	in the past 12 n 1 ☐ Yes 2 ☑ 9 ☐ Unknown	No No	4 ☐ Preg g ☐ Unki	nant at time o	f death 5	Other (spe	cify)					Monti	h	Day Y	'ear
0	iaw requires that the ras been signed by the 2 should be detach	/ Ph	Part II. Other signifi		contributing to d	eath but not r	esulting in the u	nderlying ca	ause giver	n in Part I	l:	23e. Did to	phacco	use contrib	ute to the	e cause of d	eath?
S, F	ires the signer of the signer	d by	Cong	aznis	tal h	eart	dise	ase								ably 4 🗌	
ord	w requ	Completed	0	/								24a. Was		24b. We	re autop	sy findings a	vailable
3ec	The lay	luo;										autor perfo	rmed?	dea	or to con ath? ☑ Yes		ause of
g	sian; T ertifice ctor, p		25. Was case referre examiner?	ed to medical					26. Plac	ce of Deat	th (Check o		2 (25)	ioį i L	_ ies .	2 /2.5 INU	
Ξ	Physic this co	은	1 🗆 Yes 2 🔀				ER/Outpatien			4 ∐ Nu	rsing Hom	e 5 🗌 Resid	dence (6 🗌 Other	(Specify)		
Division of Vital Records, P.O.	ding I th. After funer	Certificate:	27. Manner of Death 1 X Natural	5 Pending		of injury th, Day, Year)	28b. Time of injury	M 28	c. Injury a work?	at es 2□	- 1	d. Describe h	ow inju	ry occurred			
isio	Atten	ırığı	2 Accident 3 Suicide 4 Homicide	Investigat 6 Could not determine	be 28e. Place	of Injury - At	home, farm, stre			es Z 🗆		f. Location (S	Street an	nd Number	or Rural i	Route Numb	er.
Div	tal or rs afte al Dire ed in b		4 🗆 Homicide	determine	buildi	ng, etc. (Spec	ify)					City or Tow					,
	To the Hospital or Attending Physician. The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	edical	(Check 2		nysician: To the b miner: On the bas	sis of examinat	ion and/or investi	idation, in m	v opinion.	death oc	curred at th	e time date a	nd place	e and due to	the caus	se(s) and ma	nner stated.
	To the within To the comply	Σ	only one) 3 29b. Signature and t		urse Practioner:	To the best of	my knowledge, d		ed at the t License n		and place,			s) and mannate signed (1			
			KN		M.D.			D	52	197	-					2010)
	60		30. Name and addre	ess of person who	completed caus	se of death (Ite	em 23a) (Type, Pr	rint)	1111	21 =	00	PUET	DΛ	177 N	NDP.	E MAD	2/20
	Stat	e	•								۱ د د	rect,	/> /	1-14/1	41/6	(, ,	- 1 -
	Registra	_	3	JUL 15:	2010 32. 8	news	1. 1	arke	_								
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	(pV		30. Name and address of person wh	HEMATOLOG o completed cause of de 9i 03 FRA	_+L / /	00-\ /T D	ST D-5	51555		07/1	2/201	0
3	o the Hospi ithin 24 hou the Funer ompleted fill	Medical	(Check 2 L Medical Exa	urse Practioner: To the b	amination pest of my	and/or invest knowledge, d	gation, in my opinio eath occurred at the	n, death occurred a time, date and pla	t the time, date a ce, and due to th	ind place, ai e cause(s) a	nd due to the ca	ause(s) and manner stated. stated.
Division of Vital Records, P.O.	tal or Attending P irs after death. al Director: After t led in by the funera	al Certificate:	3 Suicide 6 Could no 4 Homicide determine	be 280 Place of Injur		ne, farm, stre			28f. Location (S City or Tow		lumber or Rura	al Route Number,
n of V	nding Physith. ath. : After this e funeral di	cate: To	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigat	28a. Date of injur (Month, Day,	у [ER/Outpatien 28b. Time of injury	t 3 □ DOA 28c. Injury work'	4 ∐ Nursing H at	ome 5 Residence 5			5y)
ital R	sician: The law significate has birector, page 2 s	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		-0.0	Othe	ace of Death (Chec	k only one)	rmed? 2 No		2 🗆 No
ecord	e law requ s has been ge 2 shou!	Completed							24a. Was autop perfo	osy	prior to codeath?	opsy findings available ompletion of cause of
s, P.O.	ires that th signed by d be detac	þ	Part II. Other significant conditions	contributing to death bu	it not resu	Ilting in the u	nderlying cause giv	en in Part I.	23e. Did to	1		the cause of death?
Box 687	e death certifica the attending p thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of 1 Live Birth 1 4 Pregnant at 9 Unknown	2 🔲 Fetal	death 3 [Ectopic pregnanc	у		23	d. Date of deli	very Day Year
260	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. with the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	conseque	ence of):						
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	conseque	ence of):						
	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. METAST	TATI		OLON	CANCER	2			Interval Between Onset and Death
ä	Imp any ono		23a. Part 1. Enter the disease, or co shock, or heart failure. List only	implications that caused	the death		Name and Addres Ouda-Ruck 7922 Wise r the mode of dying	e Ave. I	unda1k,	Mary	land	21222 Approximate
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Service Lice	ecify)	ce	emetery, crem st Law	natory or other place on Cemete	ry 7/14	/2010	Marı	riotsvi	11e, MD
e, Ma	and 2 sho Health an tem 27 is other traus		Mr. Earl Gibson 20a. Method of Disposition			3430	g Address (Street a) Sollers sition (Name of	Point Ro	pad Dur	ndalk,	Maryl ation - City or 1	and 21222
rylan	ould be file d Mental marked c matic eve	Tol	Guy Imperatore	<u> </u>				May El	izabeth	Stewa	art	2.11
d 212	ed within Hygiene. other tha	Be Cor	Elementary/Seconday (0-12) 12 Years 17. Father's Name (First, Middle, Las	College (1-4 or 5	+)	Home	emaker	18. Mother's Nan	ne (Eirst Middle		1 Home	
15-00	72 hours n "natura Aedical E	Completed	15. Decedent's (Specify only highest	grade completed)		(Give I	ent's Usual Occupa ind of work done d NOT use retired)		king	16b. Kind	of Business I	
36	after dea al", or ite xaminer	ρ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		Black, White	
	th with the ms 23a comust be	Funeral Director	3430 Sollers					21222		Unit	ed Stat	es
	or 28a-f notified	Direct	MD Ba	ltimore			Dun	da1k		10o Citiza	en of What Cou	1 Yes 2X No
	and show	tor	Usual Residence of Decedent 10a. State 10b. County			, Town or Loc	eation					10d. Inside City Limits
	Funeral Director		5. Social Security Number 213-52-0512	1 M 2-F F	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl Month, Da May I o	th y, Year 1947	9. Birth Cou Ma	nplace (State or Foreign ntry) 191and
	Examin		4a. Facility Name (if not institution, g 3430 Sollers Po	·				Location of Death		4c. C	ounty of Death Baltin	nore Co.
	Physicia Medic		Decedent's Name (First, Middle, L	Constanc	e M	lay	Gibson		2. Date of Deadonth July	ath 1 Day	201 ^{Year}	3. Time of Death 1:21 P M
		,	1 _ For State Registrar	State of Ma	aryland		tificate of E		-	Reg. No.	010	22007

DHMH 17 Rev 7/2009

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vaynoid Goillia	211	1- For State Certificate Registrar State of Maryland / Department		rygrene Reg.	No.						
Physic Medical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death	av Year	3. Time of Death 1943 hrs					
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
Funeral		2321 North Rosedale Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore If Under 1 Year If Under 24Hrs	s. 8. Date of Birth (MM/DD/YYYY) 9. Biri	hplace (State or					
Director		215-86-9847 1 1 2 F 44	Yrs. Months Days Hours Mir		Foreig						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits					
* .	ρ	MD Balti				1 Yes 2 No					
he Mary 1 or 28a- ified at	Director	10e. Street and Number 2321 N Rosedale ST.	10f. Zip Code 21216	10g.	Citizen of What Cour	ntry?					
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner, nust be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. 1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,					
fter dear l", or it		The second secon	Yes 2 No specify:	7 (104), 510.7	Specify: Blac	k					
hours a natura Examir	ted by	work done 16	Sb. Kind of Business/I								
5-0036 led within 72 hours afte Hygiene. other than "natural" the Medical Examines	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Fork	S	Sweethart	Cup CO						
21215-0036 Muld be filed within 72 Mental Hygiene, marked other than " c event, the Medical.	Be Co	17. Father's Name (First, Middle, Last) Raynold Revere Gorman Sr.		First, Middle, Maid							
Z 5 6 6 2	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or I	E. Brown Rural Route Number	r, City or Town, State,	Zip Code)					
ore, MD 21 ss 1 and 2 should of Health and Me If item 27 is ma		20a. Method of Disposition 20b. Place of Dis	8 Milford Ave E		c. Location - City or						
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is a injury or other traumatic		1 Burial 2 Cremation 3 Removal from State Crematory of Mount 4 Donation 5 Other Specify:	rother place) Carmel 7/1	4/10	Baltimo	re					
Baltimore, ME permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traums		21, Signature of Funeral Service Licensee 2.			eatherfo	rd					
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardiac c	r respiratory arrest,	shock, or heart	21213 Approximate Interval Between Onset and					
/Medical Examiner	le rea merce Characte managet a constitue de administration acceptation de la constitue de la										
	L	Sequentially list conditions, b	perthermia and der	ilyulacion							
<u>—</u>	Examiner	if any, leading to immediate — Due to (or as a consequence or); cause. Enter Underlying Cause (Disease or injury that initiated									
cuted ind transit		events resulting in death) Last Due to (or as a consequence of): d.									
60, e be exe ysician a	Medical	X UNPENDED AMENDED 23a,27,28a-f,pe 15 FEMALE: 123c If yes outcome of pregnancy	r ME g906 8/18/10	TT							
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and onpletely filled in by the funeral director, page 2 should be detached for use as the burial - transit		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna		23d. Date of delivery Month D	ay Yea r					
Box e death of the atter ed for us	Physic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	Other (Specify)								
ires that the signed by	δ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		cco use contribute to t						
ords, w require is been si	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available					
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Somp			performed 1 Yes 2							
Vital Reorysician: The his certificate director, page	o Be (25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check of Death)		sidence 6 🗸 Other:	Scene					
n of \ ling Phy After th	1.1	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Work?	28d. Describe how							
Division tall or Attendir is after death. The Director: A led in by the fu	fication	2 X Accident Investigation Fd 7.6.10 Fd 6:	30 pm	environme	nt						
Div spital or nours aft neral Di filled ir	Certification	4 Homicide Could not be determined (Specify) found at	residence	Baltimor	2321 N. H e, MD	al Route Number, City Cosedale St					
Divis To the Hospital or At within 24 hours after d To the Funeral Direc	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death ocone) 2 Medical Examiner: On the basis of examination and/or investi									
To To Con	Me	29b Signeture and title of certifier	29c. License number	29	d. Date signed (Mon	th, Day, Year)					
		30 Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	Jı	uly 7, 2010						
and		Victor Weedn MD JD Assistant Medical Examiner 111	Penn Street, Baltimore, MD	21201							
St Regis		31. Date filed (Month Day, Yar) 200 32, Resignator Signatura	raus -								

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ :15 am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner Date of Month, Day, Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Hours Min. 1 M 2 X APRI I Yrs. Director ARYLAN Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a 10b. Count 10c. City, Town or Location Director 1 Yes 2 No HIMORE IlAnd eet and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ğ Maryland 21215-0036 1 Yes 2 No Specify. 3 ₩idowed 4 □ Divorced Completed African American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRESSER HEX Cleaners othes Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KEENE-Cousin Brooks 918 MARYLAND 2/223 W. tayette Street Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 AM cemetery, crematory or other p 1X Burial 2 ☐ Cremation 3 ☐ Removal from State FOREST VA July 20, 2010 Coungs Mills MARYland SARRISON 4 ☐ Donation 5 ☐ Other (Specify) 23. Name and Address of Facility 3405 (1) FRANKLING SERVICE Sign to e of Funeral Service Licensee FUNERAL St-BALLIMORE, MARJANDERZY FRANKLIN 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consuluence of Examiner Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transi Due to (or as a consequence of) 201 resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day 1 Yes 2 No 9 Unknown To the Funeral Director; After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown of Vital Records, 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performe 2 🗆 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Hospile မှ 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t (Month, Day, Year) injury 10 Natural 2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation
6 Could not be М 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified H0010426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMENDITEM#19a, perFH, G906, 8/10/2010, WS
State of Maryland / Department of Health and Mental Hygiene 0 1 0 22010 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07⁴9-2018y 1015 P Gladys May Gossman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MN Min. Hours 1 🗆 M 2 🗶 F 108^M279-14934 Director 471-36-7724 75 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 🗆 Yes 2 No Harford Bel Air 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 21015 723 Beretta Way items death 12. Was Decedent Ever in U.S. Armed Forcess? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 10 t þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced "natural", Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Bell Atlantic Operator other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Mundstock Lawrence Nicklay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
723 Beretta Way Bel Air, MD 21015 Norman Gossman (Son) (husband) 723 Beretta Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury or Bel Air, MD Bel Air Mem. Gardens 07-16-2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir Signature of Funeral Service Licensee anyi Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final DEC Physician/ disease or condition resulting in death) aus Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? à WITH Coaquipathy 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NASAUL Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 🔼 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one and title of certifier 29b. Signatu 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

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TUNSON Mr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31 Date filed (Month, Day, Year)

1103

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien (2) For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AIG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel **Annapolis** Anne Arundel Medical Center Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day) Country Months Days Hours Min Year) 1960 Director 220-80-5287 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Yes 2 No Glen Burnie Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 21061 401 Hideaway Loop 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Genesis Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Doris Osborne Donald Green Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Hideaway Loop Glen Burnie, Maryland 21061 Lashella Green 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State Pasadena, Md. 07/17/10 4 Donation 5 Other (Specify) Mt. Zion Church Cemetety Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore. Md 21217 Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line Immediate Cause (Final lou Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ pe Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, it is a filled in by the funeral director, it is a filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? Other: Certificate: To 🗹 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 Yes 2 No Accident Investigation Could not be Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis
3 Certifying Nurse Practioner Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number and address of per use of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State

DHMH 17 Rev 7/2009

Registrar

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	Director		215 • 84 - 7579 Usual Residence of Decedent	1 [344 2 F L	17 Yrs.	Months Da	ys Hours Min.	8. Date of Birth (Manth, Day, Yes	962	intry) MD
	laryland 3a-f shor	ector	10a. State 10b. County	more	0c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ♠ No
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Maryland	should the and Me is mark		19a. Informant's Name/Relationship (ng Address (Str	eet and Number of Ru		. ~	o Code)
	and 2 s Health em 27 ther tra	. 60	Ellis Goode 20a. Method of Disposition	TTT (201	20b. Place of Dispo	7 Nou		Date 2 200	Sex, M.L.	7 2 2 2 1 2 2 1 Town, State
Baltimore,	Page 1 nent of int: If it iry or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State		m atory or other		15 2010 C	· · · · · · · · · · · · · · · · · · ·	HITS.MD
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Box 68760	n certific ending r use as	an/M	IF FEMALE: N/A 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live Birth 2	pregnancy Fetal death 3	☐ Ectopic pregi	nancy		23d. Date of de	·
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ita 🖟	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:			6. Place of Death (Che			
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Division	tal or A irs after al Direct led in by	Cer	4 Homicide determine	d building, etc. ((Specify)			City or Town, S	State)	
7	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral director.	Medical	(Check 2 Medical Exa	nysician: To the best of my miner: On the basis of exa arsa Fractionar To the be	mination and/or inves	stigation, in my o	pinion, death occurred	at the time, date and p	place, and due to the	cause(s) and manner stated.
15	To the within To the comp	2	29b. Signature and little of certifier	>	•		cense number		J. Date signed (Mont	
			30 Name and address of person who	completed cause of dea	oth (Item 23a) (Type	Print)	51966	1 N Belv	edere t	tve
			Minerva Rome	in Avenas	LIMD, Si	naittos	240 pital of B	altimore	ealtim	ore MD 21215
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	get !	7:			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per me, g905,07/15/2010dhb certificate of Death For State Registrar 22013 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 18:45 Jano ead June Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death yland Medical Center altimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F May 11, Year 1989 21 Months Hours Min. 212-25-1311 Mary land **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Direct Baltimore Parkville 1 Tes 2 X No Maryland 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? Examiner must be 23a Funeral 1 Montauk Court 21234 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ò 1 Never Married 2 Married Completed by Yes 2 X No Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White "natural" 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Student Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Billy Ray Fannin Kathleen L. Glancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen L. Glancy, Mother 1 Montauk Court Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Metro Crematory Inc. 06/19/10 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor 22 Name and Address of Facility Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Traumatic Priysician/ brain CENTRICATION APPROVED THE EDICAL CEMM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner barachnoid Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events the burial-transit and resulting in death) Last Due to for as a consequence of the attending physician hed for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ detached for in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ page 2 should be neumothor Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Tes 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar has autopsy perform certificate 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending n 24 hours after death.

le Funeral Director: Aft
pleted filled in by the fur Motor vehicle 2 Accident June 11, 2010 12:30 1 🗌 Yes 2 🕎 No collision Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) mpleted filled in by determined Street imonium Teaneck Medical 29a. Certifier Kcrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 the hin 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 2 29d. Date signed (Month, Day, Year) 366267 July 14, 2010

State Registrar 30. Mar

1. Date filed (M

Sattimore

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le and address of person who completed cause of death (Item 23a) (Type, Print

Registrar's Si

Pay 1 5 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [7] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ ^{Day} 2010 1:30 P Joseph Phillip Hamper, Jr. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death #508 1055 W. Joppa Road, apt. Baltimore Towson Social Security Number 8. Date of Birth (Month, Day, Jan 28, If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F 1926 Maryland Director 220-22-7099 84 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 21204 1055 W. Joppa Road, apt. USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, <u>م</u> 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed 3 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Abntal Hyglene. Important If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ŏ4 Financial Vice President Sports Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip. Belle Insley Hamper, Sr. Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30294 Calhoun Avenue, Salisbury, MD 21804 Werner Gruber/Cousin 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/22/10 1 X Burial 2 Cremation 3 Removal from State Donation 5 - Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 21 Signature of Funeral Service Licenses Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. Enter the cisease, or complications that cauted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cluse on each line. Immediate Cause (Final disease or co in resulting in death) Onset and Death Physician/ Due to (or as a consciuence of): arten Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or imjury burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10000 05 July 14, 2010 D., 10753 Falls Road, Suite 225, Lutherville, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 Todd Baldanza, M.D. State Registrar

Maryland

Baltimore,

P.O. Box 68760

Records,

Division of Vital

		_	For State	State of Mar	ryland	-	rtmen tificate			and M		giene Reg. No. (010	22015
			Registrar 1. Decedent's Name (First, Middle, Las	st)		0011	imour		-		2 Date of Dea	ath		3. Time of Death
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مر			3 REGENCY COURT 5. Social Security Number 6. S	ev 7 Age	(In yrs. last	hirthday)	BA If Under	LTIMO	JKL If Under	24 Hrs.	8. Date of Birt		ALTIMO 9. Birth	pplace (State or Foreign
	Funeral Director			X M 2 □ F	80	Yrs.	Months	Days	Hours	Min.	02/167			PA PA
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	or 28g	Dire	MD BALTIN 10e. Street and Number	TORE	DF	AL I INC	10f. Zip	Code				10g. Citizen	of What Cou	
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<u>a</u> 2	2 should be tth and Ment 27 is marke traumatic		19a. Informant's Name/Relationship (7	Type, Print)							l Route Numbe			Code)
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Baltimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam any injury or other traumatic event, the Medical Exam ponee.			1 🕅 Burial 2 □ Cremation 3 □		cen	netery, crem SHAL(natory or o	ther place			/2010		-	ΓOWN, MD
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	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Σ	only one) 3 L Certifying Nu 29b. Signature and title of certifier	Tae Fractioner: 10 the D	Jeac Or Hily I	owiouge,	29	c. License	number	, Line pide	,	29d. Date si	gned (Monti	n, Day, Year)
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	Funeral Director		5. Social Security Number 217-26-6817		day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 2 Month, Day	920 g. B. C. Man	rthplace (State or Foreign ountry) ^y land		
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Baltimore, Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 【 Married 1 ☐ Never Married 2 】 Married 1 【 Yes 2 ☐ No If Yes, Give Year or Dates. WW		13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No		Rican, etc.)	Black, Whi	te, etc.		
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Division of Vital Records,	after d after d Direct d in by	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - Af building, etc. (Spe		n, street, factory, office		28f. Location (S City or Town	treet and Number or Ri n, State)	ural Route Number,		
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			► nskajapahnenio			57465		7/8/			
			30. Name and address of person who completed cause of death (II N.S. Rajnpa KSE, M.D. 283	tem 23a) (Ty 5 Sm	pe, Print) Th Av- S-Z	35 B	a Itimor	e, MO.	21209		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	iato or mary		rtificate of L			Reg. No.	010	22017
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Iam	<u>-</u> -			2. Date of Dea Month	ath Day 9	2010	3. Time of Death
• .	Medic Examin	al	Katina Lee F 4a. Facility Name (if not institution, give street	and number)		4b. City. Town, or	Location of Death	7		2010 County of Death	
-	LXaniii	CI	Baltimore Washington		Center		len Burni	е	40.0	•	Arundel
	Funeral Director		5. Social Security Number 215-19-6424 6. Sex	o XE	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 05/05/			hplace (State or Foreign Intry) MD
	and Show Lat	or	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
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	n with the	Funeral Director	10e. Street and Number 203 B Court			10f. Zip Code	20711		10g. Citize	en of What Cor	untry? S . A .
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	1 XNever Married 2 Married 1	vas Decedent Ever in vmed Forces? ☐ Yes 2 █ No Yes, Give ear or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White pecify: A	
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Baltimore, Maryland 21215-0036	und 2 sho fealth and fm 27 is r her traun		19a. Informant's Name/Relationship (Type, Pr Mr. Duk Hwan Han / 1	ather	918	ng Address (Street a			os Ai	ngeles,	CA 90006
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Division of Vital Records, P.O.	al or Attending Phys s after death. Il Director: After this d in by the funeral d	Certificate:	3 Suicide 6 Could not be	le. Place of Injury - A building, etc. (Spe	t home, farm, str	eet, factory, office		28f. Location (S City or Tow		Number or Run	al Route Number,
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			Registrar 1. Decedent's Name (First, Middle,	ast)			Cer	lilicate	; UI D	eaui		2. Date of Dea	Reg. No.		3. Time of Death
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	Medic Examin	_	4a. Facility Name (if not institution, o			-			Town, or	Location o	_		4c. Cou	nty of Deatl	
			Gilchi	ist Center for								son			timore
	Funeral			i.Sex 1 □x/M 2 □ F	7. Age (In y		thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Oct 1	h 2 Year) 1951	g. Birt Cou	hplace (State or Foreign Intro) Maryland
	Director	ŀ	214-56-0021 Usual Residence of Decedent			58	1101					Oct 1	2, 1001		
	shov dat	ē	10a. State 10b. County		10c	. City, Tow	n or Loc	cation	-	- 645					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
:	Mary 28a-f otifie	Director	Maryland	N/A				1		altimor	e 				
:	th the	ral D	10e. Street and Number 3415 Spelman Road					10f. Zip	Code	212	225		10g. Citizen	U.S	
	ath wi	Funeral	11. Marital Status	12. Was Dece	dent Ever in	n U.S.	13. V	Vas Deced	ent of His	spanic Ori	gin? (Spe	cify Yes or No-	14. [Race - Ame	rican Indian,
9	er de or ite		1 ☐ Never Married 2 ☐ Marrie		2 X No		-1	fYes, speo ∣ ☐ Yes				Rican, etc.)		Black, White	e, etc. Black
ලි ි	ursaf ural" al Exa	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes.								Spe		
15	72 ho n "nat 1edica	nple	15. Decedent (Specify only highes	grade completed)		16a	(Give I	lent's Usua kind of woo O NOT use	k done d	ation <i>luring mo</i> s	t of worki	ng	16b. Kind o		of Maryland
712	vithin jiene. sr thau the N	ပ်	Elementary/Seconday (0-12)	College (1-	-4 or 5+)					sekeep	ing			liversity	
bu	filed v al Hyg d othe		17. Father's Name (First, Middle, La							18. Moth	er's Name	e (First, Middle,	Maiden Surn Brace Jo		
yla	uld be Ment narke natic e	입		irew Jones											- 0-4-)
Mai	2 shou th and 17 is n traum		19a. Informant's Name/Relationshi Shirley Jones	p (Type, Print)		191	b. Mailir 3	ng Address 8 415 St	s (Street a celma r	Road	Baltim	l Route Numbe ore, Maryla	and 2122	n, State, Zij. 5	o Code)
ē,	Healt Healt		20a. Method of Disposition			0b. Place o	of Dispo	sition (Nar	ne of		[Date	20c. Locati	on - City or	Town, State
m0	Page nent or nrt. If ry or		1 ☐XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State			natory or o			eum	07/19/10	Ε	3rooklyn	Park, Md.
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu Service Li	censee	-	-	22	. Name ar	d Addres	s of Facili	ty S Fune	eral Service	e. P. A.		
_			23a. Part 1. Enter the disease, or o	UL	Co	1/			1300 E	utaw F	lace E	eral Service Saltimore, N	//d 21217		Approximate
			23a. Part 1. Enter the disease, or on shock, or heart failure. List or immediate Cause (Final	omplications that only one cause on ea	ch line.	greath. Do	not ente				cardiac	or respiratory ar	1651,		Approximate Interval Between Onset and Death
~ P	h, sician/ Medical		disease or condition resulting in death)	a. Que to	or as a con	Of	off:	ph	ary	np					
-	Examiner			Due to	or as a con	isequerice	Oi).	•							
, 11, 1		iner	Sequentially list conditions, if any, leading to immediate cause. Litter Underlying	b. Due to	or as a cor	sequence	of):								
30	cuted nd transit	xam	Cause (Disease or linjury that initiated events	C. Due to	or as a cor	2000110000	of:		_						
	e exe cian a surial-	dical Examiner	resulting in death) Last	Due to	or as a cor	isequence	01).								
200	cate b physi s the b	edic		d											
89	certifi inding use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pr Birth 2	egnancy Fetal dea	th 3	☐ Ectopic	pregnanc	:v			23d	. Date of de	
Box 68760	death ne atte ed for	Physician/Me	in the past 12 months? 1 Yes 2 No		nant at time			Other (s	pecify)	,				Month	Day Year
0	at the d by th etach	Phy	9 Unknown Part II. Other significant condition	s contributing to d	eath but no	ot resulting	j in the ι	underlying	cause giv	en in Part	l.	23e. Did t	obacco use o	contribute to	the cause of death?
ω̈́.	res tha signe d be d	d by		_								1 2	Yes 2 🗆 N	10 3 □ F	robably 4 🗆 Unknown
ord	been shoul	Completed										24a. Was		4b. Were au	topsy findings available completion of cause of
ec	ne law te has age 2	duo											psy ormed? 2 2 No	death?	s 2 No
al F	ian: T rtifica stor, p	BeC	25. Was case referred to medical examiner?								ath (Chec	k only one)			
Zit Zit	hysic his ce	₽	1 Yes 2 No		Inpatient		_			4 ⊔ N		ome 5 Resi			city) MOSPLIE
n of	Jing P h. After t funera	ate:	27. Manner of Death 1 Natural 5 Pending	} `	of injury th, Day, Yea		Time or injury	' _м [28c. Injur work 1 □	yan ⟨? Yes 2.[l	28d. Describe	now injury oc	currea	
Siol	Attend r deatl sctor: by the	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place	of Injury -	At home, f	farm, str							ımber or Ru	ıral Route Number,
Division of Vital Records, P.O.	tal or a safte al Dire	0 0		Dullai	ng, etc. (Sp							City or To			
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Chook 5 Medical F	Physician: To the base	sis of exami	ination and	/or inves	stigation, in	my opinio	on, death c	occurred a	t the time, date	and place, and	d due to the	cause(s) and manner stated.
	o the vithin 2 o the o omple	ž	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner:	To the best	of my know	wiedge,			e time, dat e number	e and pla	ce, and due to the			h, Day, Year)
	F > F 0		> (Alland	W)					D	55	33 C	3	201	4 17	2010
	H		30. Name and address of person v	vho completed caus	se of death	(Item 23a)	(Type, I	Print)	(111	4161	Cr	- 1714	SIALA	10	
	Sta	to	31. Date filed (Month, Day, Year)	32. F	Regietrar's S	Signature	14	101	NU	vus	21	100	<i>V</i> / V / C	10	
	Registr		JUL 1	52010			8	1	-						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2010 /Medical County of Death Town, or Location of Death 4b. City. 4a. Facility Name (If not institution, give street and number) Examiner RUNDEL IRNOLD esapeake UTURECAP f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) ecurity Numbe 7. Age (In yrs. last birthday Funeral Months Days Hours Min. 1 □ M 2 ☐ F 80 214-28-2168 03/21/1930 MD Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location show Pages 1 and 2 should be filled within 72 hours after death with the Maryla ment of Health and Mental hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, I'm Nesten Exanders in not be mailted at 1 ☐ Yes 2 No Glen Burnie Director Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21061 Hopkins Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Motor Vehicle Elementary/Secondary (0-12) 12 College (1-4or 5+) Administration Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Lusby John Carvel Sutton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glen Burnie, Maryland 21061 1 Hopkins Street, Mr. William E. Jones / husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Maryland Department of Important: If any injury or Glen Haven Mem. Park 7/13/2010 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. MO1357 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ORO BROVASCULAR ACCIDENT Immediate Cause (Final HOUPS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 Probably 4 Unknown HYPERTENSIIN Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes after death.

Director: After this certific
d in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 □ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Pereposition Millersune ND 2110 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

22020 State of Maryland / Department of Health and Mental Hygien 20 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Day Month **Physician** Elizabeth Pauline Kearney 2010 0325 М JYIV 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Agres Hospita If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 23, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 □ M 2 🖫 F 405-52-6481 81 Dec. Kentucky Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it e Medical Examinational to another traumatic event, it e Medical Examinational to another. 1 ☐ Yes 2 No Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5719 Edmondson Avenue 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No White. Specify: 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Simon Childs Clarkson Pauline Furlong ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Philip Kearney Son 6 Old Granary Court; Catonsville, MD 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 7/15/2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lice MO1050 Hade 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) herosclerosis **Physician** /Medical Due to (or as a consequence of): **Examiner** Peripheral Vasialas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran and Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Únknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. Certification: To after death. Director: After this 27. Manper of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ∐Yes 2 🗋 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only one) Medi and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jyl 10, 2010 Buddenside AS24385284430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19201 Groyenglake#812 Rockville, MD 20852 nas Buddersich Registrate Sectors State

DHMH 17 Rev 1/2001

Registrar

ZABETH

[1]

LEARINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** DOLORES MARGARET KOPP 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Bal Center Hospital Kose al timore If Under 24 Hrs. If Under 1 Year Age (In yrs. last birthday) 81 Yrs. Birthplace (State or Foreign Country) **Funeral** 217-26-1916 Days Months 1 □ M 2**X**□ F 5-3-1929 MARÝLAND Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examiner, ust be nothing at MD BALTIMORE KINGSVILLE 1 ☐ Yes 2 XNo Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 11803 CHAPMAN ROAD 21087 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married than "natural", or 1 □Yes 2 No þ Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL CLOTHING permit. Pages 1 and 2 should be file Department of Health and Mental th Important: If Item 27 Is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANDREW SADILEK MARGARET ပ (GEARGHTY) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MARY ELLEN MEMERY/DAUGHTER 1202 HILLDALE ROAD ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXurial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 7-17-10 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Brons **Physician** hopheumon disease or condition resulting in death) /Medical Due to (or as a conseque ce of): Examiner 515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ras a consequence of: Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) ed by the a 9 ☐ Unknown cate has been signed , page 2 should be dete 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 □ No 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗹 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. May er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Kottarat

To the

9000 Fr

and manner stated.

M.D.

32. Regist ar's Signature

No Hantil and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

13/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-05224 2010 22022 State of Maryland / Department of Health and Mental Hygiene John Joseph Kahler Certificate of Death 1. For State Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First_Middle.Last) Physician/ Month 1340 hrs John J. Kahler July 12, 2010 **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore N/A 935 Armstead Way If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Country)Maryland Months Days Hours April 9, 1946 Director 218-42-8445 64 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10a State 10b Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature!" N/A Baltimore Maryland 1 X Yes 2 No 28a-f show Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 935 Armstead Way 21205 U.S.A. Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces Never Married 2 X Married Yes 3 Widowed 4 Divorced Yes. Give Year 1 Yes XX No specify: Specify: White ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Unknown Unknown Unknown 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Weatherstein Albert Kahler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frances Kahler - Wife 935 Armstead Way 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Cremation Set. 7/15/10 Glen Burnie, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Charles S. Zeiler & Son, Inc.
6224 Fastern Avenue Baltimore,
23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical 23a,pt.II.27 per me g906 8-17-10 vt **X** UNPENDED ş Completed

the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - trans Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certifi
completely filled in by the funeral director,

Be

Certification: To

Medical

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

F FEMALE: Bb. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions Chronic Obst	s contributing to death but not resulting in the underlying cause given in Part I. ructive Pulmonary Disease	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 Yes 2 V No 1 Yes 2 No
5. Was case referred to medical	26.Place of Death (Check on	ly one)
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing	
7. Manner of Death 1 X Natural 5 Pending	(Month, Day,Year) 1 Yes 2 No	8d. Describe how injury occurred
2 Accident Investiga 3 Suicide 6 Could no determin	ot be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of my knowledge, death occurred at the time, date and place, and diter: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	ue to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

DOME

July 13, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 | 0 Certificate of Death 2. Date of Death s Name (First, Middle, Last) Year 10 Physician/ A M Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAYVIEW MEDICAL CENTER ALTIMORE 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Hours (Month, Day, Country) **Director** 237-30-7519 91 0 - 8 - 1918NC Usual Residence of Decedent 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location Director 1 □XYes 2 □ No MD Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 616 South Quail Street 21224 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian. 11. Marital Status "natural", or iter Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates Specify: 3 → Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cager McLamb Hattie Watts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freida Powell - Daughter 7862 St. Monica Dr., Dundalk, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury or Oak Lawn Cemetery 7-13-10 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee 2134 Willow Spring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions cause. Enter Underlying Exami ROSEPSIS or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 1 Yes 2 9 Unknown be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has page 2 hours after death. uneral Director: After this certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🗹 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 - Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue.

Battimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 | 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1325 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Margland Medical

6. Sexy 7. Age (In yrs. las 0 Ba more If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, If Under 1 Year Months Days Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** 2010 Min. Hours 1 M 2 □ F Months **Director** Maryl Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director rumbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WOCK WOC Never 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be te head iara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (mother) # permit. Pages 1 and 3 Department of Health Important: If item 27 I any Injury or other tra once. 12 liara Dr. alumbia WD Iamar Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, enmount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 1845 Funeral Home, P.A. 2222 W. North Avenue Balto, NO 21. Signature of Funeral Service Licenses Tatelle X.M Lacrus 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician xlvem disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) cate has been signed by the page 2 should be detached 1 □Yes 2 □ No. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed' 2 **EN**O 1 ☐ Yes 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 21KLINo 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Injury Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month,

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who completed cause of death (Item 23a) (Type, Print

225

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20067

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 22025 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 12.2010 5:00A John A. Lang М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson4c. County of Death Balto. Examiner Gilchrist 5. Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 6. Sex 1 ፟ M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days July 1, 1915 Maryland Director 212-03-5051 95 Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Balto. 1 Tes 2 X No Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21236 9409 Dana Vista Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No 1 ☐ Yes 2 ← No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 1945-1945 White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Electrician Aircraft Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Lang Dorothy Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen L. Lang Spouse 9409 Dana Vista Road Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 7-17-2010 Moreland Memorial Parkville, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ omplication disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Day Pregnant at time of death Yes 2 No 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 M Other (Specify) W 3 ρ (Ψ Hospital 2 X No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier FCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Clarles

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

6701

WHILKES

/(1)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4.46pm John Loyal Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Union Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 → M 2 □ F Months Days Hours Min Country Director Yrs. 218-48-1803 Nov 24 1945 So. Carolina Usual Residence of Deceden or 28a-f shov notified at show 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/A **Baltimore** Maryland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be with 1 Funeral 3426 Cardenas Avenue 21213 U.S.A death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 72 hours after 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exar 1 Yes 2 No Specify. 3 → Widowed 4 □ Divorced Completed Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Coca Cola Company Employee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ David H. Hill Thelma Godwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3426 Cardenas Avenue Baltimore, Maryland 21213 John Loyal, Sr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 🕏 ☐ Other (Specify) 07/14/10 Catonsville, Maryland Metro Crematory, Inc. 21. Sign tur of Fineral Service Licen 22. Name and Address of Facility Estep Brothers Funeral Service, 1300 Eutaw Place Baltimore, Md 21 Part Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Myocardia Medical Due t (or as a consequence of): Examiner te nscor Se grentially list non-fittions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir ending physician and use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year cate has been signed by the page 2 should be detached g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed?
Yes 2 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after death.

e Funeral Director: After the letted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D0066212 08,2010 Duly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway Baltimore, Maryland 201 East University McClockin 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anna V. Lyons 2010 1742 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico REGIONAL If Under 24 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 12/30/1946 Country)
Maryland 1 □ M 2 🕱 F Months Days Hours Director 217-50-4553 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 240 Brentwood Circle 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give þ Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ticket Agent Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Major Virginia Gabler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 240 Brentwood Circle, Glen Burnie, Maryland 21061 Mr. Gerald L. Lyons (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State onation 5 Other (Specify) Loudon Park Cemetery: 07/16/2010 Baltimore, Maryland 21 Silmat of Funeral Service Licerse 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSIVE ATHEROSCIEROTIC Physician/ disease or condition Medical resulting in death) Examiner CARDIOVASCULAR DISCASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PNEUMONIA. CAD s/p CABG. 1 Yes 2 No 3 Probably 4 Unknown OBESITY. HYPERTENSION. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No DIABUTUS MELLITUS. certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the fullen 28d. Describe how injury occurred X Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Kacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 3 🔲 29b. Signature and title of efftifier 29d. Date signed (Month, Day, Year) when si 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARRELL ST JWIERHOSZ MI) 32. Registrar's Signature State Registrar

Elease Type of Print in Alack Andeliale Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:50 P Day Year Month **Physician** 3 Robert McAllister Sr. 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner KALTIMOre Agnes Hosp If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
05 03 2 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1XM 2□ F Months Hours 29 SC Director 81 248-20-5708 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Me Acol Exa. in activust be traumatic at 1 TWes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10e Street and Number 10f, Zip Code U.S.A. 3211 Brighton Street 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black White etc. Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 【YNo Specify Black Specify. þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Steel Worker Bethlem Steel Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ည Willie McAllister Pearl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sl ment of Health an 2919 Riggs Ave, Baltimore, Md 21216 Maxine Moore-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 7/22/2010 Owings Mills, Md 4 Donation 5 ☐ Other (Specify) 21. Sd pf Funeral Service License March Fyn West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vascular UKnavin bronary disease or condition resulting in death) /Medical Due to (or as a conse wince of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. ☐Yes 2☐No the 9 Hlnknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed pertension 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? High Cholestero certificate Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CatoN AVE BALTIMORE 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per dos 705 of Fleath and Mental Hygiene 22029 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Juanita A. Miller July Physician/ 2010 2 7:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Carroll Westminster Dove House If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Sept. 18, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 M 2 D F Director 88 212-16-5461 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Westminster MD Carrol1 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21158 2323 Littlestown Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. .0 Black, White, etc. 1 ☐ Never Married 2 🔀 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Branch Manager Banking 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William G. Keefer Mary E. Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 Littlestown Pike; Westminster, MD 21158 Husband Arthur D. Miller 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 and Department of F 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 7/8/2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Sterling Ashton Schwab Witzke uneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Servi Licensee 23a. Part 1. Enter the disease, or complications that cal Approximate Interval Betw shock, or heart failure. List only one cause on ea Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) 2 No the a Unknown a I Inknown Division of Vital Records, P.O. by To the Hospital or Attending Physician: The law requires that: within 24 hours after death.

To the Funeral Director: After this certificate has been signed be completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending 2 🗌 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie completed cause of death (Item State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Irene Virginia Meyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** mnd len IShir vo) Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y April 21 Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 1 1921 Director 89 MD 212-18-7523 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. sant. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7355 Furnace Branch Road 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 2 Baltimore, Maryland 21215-0036 1 Yes 2X No Specify White Specify. 3 🔀 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Executive Secretary State of Maryland Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Fuller Unknown Lelia King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7803 Bodkin View Drive, Pasadena, MD 21122 Greg E. Meyd (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State July Glen Haven Cemetery 4 Donation 5 Other (Specify) Glen Burnie, Maryland 2010 21. Sign tun of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD 21122 23a. Part | Enter the disease, or complice shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Fina **∲nysici**an∌ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) bunial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the k IF FEMALE for use 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown Records, P.O. The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 2 No 1 Yes or Attending Physician; **Division of Vital** æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending work? 1 Yes 2 No M Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatur and/title of certit signed (Mothth, Day, Year) on who completed cause of death (Item 23a) (Type, Print 019 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Amend Item 25 per me,g906,08/06/2010dhb Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O/C 4:05 PM Marcus McKay Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A OF Hospital Baltimore 1+more 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖳 M 2 🗆 F Months Hours Min. (Month, Day, Year) Feb 9, 1955 Maryland Director 215-60-5142 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Marcus or 28a-f sl notified 1 Yes 2 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö : If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be Funeral U.S.A. 21215 3520 West Belvedere Avenue 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 Divorced 4 Divorced Knownas Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U. S. Post Office permit. Page 1 and 2 should be filed within . Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Zula McKay John McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3520 West Belvedere Avenue Baltimore, Maryland 21215 Zula McKay 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn Park, Md. 07/15/10 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery & Mauscleum 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tro peritoneal disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, Examine Diwite (or as a nonsequence of) if any leading to immedicause. Enter Underlying the attending physician and hed for use as the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical しから かんり かんり かんり Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 4 Pregnant : 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown יי שוס די מויפים ושופל a rurector. After this certificate has been signed by ז completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HIV/AIDS, End-Stage renal disease 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Hypertension, Anemia, Coaquio pathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manne Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred work? injury Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 31. Date filed (Month, Day,-Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health, and Mental Hygiene
Amend Items 4a,28e per me, g905,07/15/2010dhb

Certificate of Death

Reg. No. for State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Charles B. Moscardini Medical 4a. Facility Name (if not institution, give street and number)

405 Millian Drive Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Her pitol If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 X M 2 □ F Months Days Hours Oc (Month, Day 1959 California 50 Director 561-35-7094 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matitied at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Capitol Heights 1 🗆 Yes 2 🔀 No 10g. Citizen of What Country? 10e. Street and Number 405 Milfan Drive 20743 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 2 □ No 1979-Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 ☐ Widowed 4 🔀 Divorced 1986 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) engineer electrical design Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward Moscardini Marlene Pear 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Moscardini - brother 1421 C Street; Hayward, California 94541 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 21. Signature of Eurera Service Licensee Nay1 22. State Anatomy Board; 655 W. Baltimore Street an Baltimore. Marvland 2120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pflysician/ Atheroscher 7 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atternorpheted filled in by the funeral director, page 2 should be detached for completed filled in by the funeral director, page 2 should be detached for contracts. in the past 12 months?
1 ☐ Yes 2 ☐ No Month Veat Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22033 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Jon Philip Nusbaum 4:40 P M Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg Montgomery 16504 Montecrest Lane 5. Social Security Number 8. Date of Birth (Month, Day, May 18, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1945 1 🛛 M 2 🗆 F Months Days Hours Director 215-44-4237 Yrs 65 Maryland Usual Residence of Decedent 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.

The state of the thing of the state of the stat 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Montgomery Gaithersburg 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16504 Montecrest Lane 20878 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) design and Elementary/Seconday (0-12) College (1-4 or 5+) 12 sign manufacturing 3 vice-president Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 or other traumatic Patrick H. Nusbaum Constance Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason C. Nusbaum/ son 16504 Montecrest Lane Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) County Cremation 7/13/2010 Sykesville, MD 21. Senator & Funeral Service Licens 22. Name and Address of Facility Hartzler Funeral Home 310 Church New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Renal cell carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 month <u>Metastasis to bone</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 XNo 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

completed cause of death (Item 23a) (Type, Print)

f pe

2101 31. Date filed (Month

		-	For State Registrar	State of Mary		partment of H e <i>rtificate of D</i>			Reg. No.	22034	
Г	Physicia		1. Decedent's Name (First, Middle, Last	AUGUE				2. Date of Dea	ath Day 2 2as	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number)			4b, City, Town, or Location of Death			4c. County of Death		
The same of			CollegeView Center			FREDERICK FREDERICK			RICK		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. Mar. 27, 1927 Maryland Maryland								
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1 1	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
		Director	Maryland Frederick 10e. Street and Number			Keymar 10f. Zip Code			10g. Citizen of What C	1 Yes 2 X No	
		Funeral	12022 Legore Br:	idae Rd.		21757			U.S.A		
Maryland 21215-0036			11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)		erican Indian,	
		Completed by	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specific	hite	
15-0			15. Decedent's Education (Specify only highest grade completed)		(Giv	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business Industry		
212			Elementary/Seconday (0-12) College (1-4 or 5+)		me.	seamstress			sewing factory		
pu		To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, I					
ryla		٦	10a Informantia Nama/Dalatianahia /Tu	Margaret Catherine Weddle ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Larry R. Naugle/ son 5637 Denton Ct. Frederick, MD 2								
ore,			20a. Method of Disposition 1 Burial 2 Cremation 3	20	0b. Place of Dis	position (Name of rematory or other place		Date	20c. Location - City o		
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify)	Mt. Hop	e Cemetery		/2010	Woodsboro		
Bal			21. Sign of of Funeral Service License (aff) area.	Xarpler	/	22. Name and Addres			Funeral Homoro, MD 217		
	Physician/ Medical Examiner		shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
		Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	С							
_		al E	resulting in death) Last	Due to (or as a cor	Due to (or as a consequence of):						
1200		Medical		d							
. Box 68		Physician/M					ctopic pregnancy ther (specify)			23d. Date of delivery Month Day Year	
s, P.O.		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
of Vital Records,		Completed						24a. Was		utopsy findings available completion of cause of	
Rec	The law cate has I	Com							ormed? death?		
ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? Hospital: 26. Place of Death (Check only one)								
of V	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completed filled in by the funeral direction.	e: To	1 Pes 2 Position 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
on 0		ficat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No							
Division		Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		-	29b. Signature and title of certifier			29c. License			29d. Date signed (Mon	th, Day, Year)	
			- Ole	MD		D60			7-14-2		
	21	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen shah, 65c Thomas Johnson Dr. Frederick MD 21702									
State Registrar			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Shah 65c Thomas Tohnson Dr. Frederick MD 21702 31. Date filed (Month, Day, Year) 32. Registral Signature JUL 152000 Registral Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 14 Physician/ 6.10 M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y 1 ☐ M 2 🕱 F 82 Months Days Hours Min. Maryland **Director** 012-42-7543 928 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Howard Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1525 Marriottsville Road 21104 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 X Never Married 2 Married 9 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Augusto Neville Ella M. Siegfrid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Frances McCabe Pers. Rep. 1525 Marriottsville Road, Marriottsville, MD 21104 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery 7/20/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee M0105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Embolism Onset and Death Immediate Cause (Final Imonar Physician/ 12 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examin The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Pregnant at time of death ed by the detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending 2 Accident 3 Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12 2010 Name and address of person who completed cause of death (Item 23a) (Type Print) 20 Sack 105 Sahapa

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registra

s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perPHYS, G905, 7/15/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 22036 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20^{Year}0 Cecilia Mae Reynolds 2:01 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner na Baltimore 2614 Brendan Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X X Months Hours Min 098-20-5765 T926 S.C. Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County must be notified at 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director Baltimore MD na 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 2614 Brendan Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Black 3

Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home 12th grade 17. Father's Name (First, Middle, Last) Housewife Be 18. Mother's Name (First, Middle, Maiden Surname) ည Peter Mealing Rosie Prescott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Allen-Daughter 2614 Brendan Avenue Balto, MD 21213 other 1 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 7-8-2010 4 ☐ Donation 5 ☐ Other (Specify) Timonium, permit. Signature of Funeral Service Licenses 22. Name and Address of Facility March East F/H Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -UNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner EMBOLIJM MONARY Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for se a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery Month 4 Pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> CORONARY ARTERY DISEASE Completed 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes ABDOMINAL ADRTIC ANEURISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy HYPERTENSION 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 ☑ Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

MD

SABAEVA, ELENA;

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2069765

5601 LOCH RAVEN BLVD, BALTIMORE MD, 21239

2010

	1	For State	State of N	/laryland		artment of rtificate of		and Men		ene 0	10	22037
Physicia	_	1. Decedent's Name (First, Middle, I				Roll	ins	1	Date of Death Month	Day	Year	3. Time of Death
/Medica	1 0	Ruth 4a. Facility Name (If not institution, g	ive street and numbe			4b. City, Town,			07 1	2 20 4c. County	O10 y of Death	4:20a. M
Examine	3	Envov of Pike	sville N	ursin	ng Ho		ikesv			В	alti	
Funeral Director		5. Social Security Number 6 579-12-3696	. Sex 1 □ M 2 🔀 F	Age (In yrs. I	last birthday)	If Under 1 Yea Months Days		Min. 8. 1	Date of Birth Month, Day, 1	13	9. Birth	place (State or Foreign ntry)
and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
Maryli Ff sho	į	MD NA	1		Bal	timore						1 □X/es 2 □ No
or 28a	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of		
s 23a		7404 Liberty F	Road 12. Was Decede	nt Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu	21207 Hispanic Ori	igin? (Specify	Yes or No-	14. Ra	S A	can Indian,
yiand Z I Z I 3-0030 uld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural" or items 23a or 28a-f show atte event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	Armed Force	ş? ☑ No		If Yes, specify Cu 1 ☐ Yes X☐ No		n, Puerto Rica	an, etc.)		ack, White, ify: ${ t B1}$	
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Maryland ZIZIS 12 should be filed within 7 12 and Mental Hygiene. 7 is marked other than "r fraumatic event, the Mec	E O	Elementary/Secondary (0-12) 4th grade	College (1-40	or 5+)		Domest:	_				ivat	e
d be filed bental Hyg ced other c event,	Be C	17. Father's Name (First, Middle, La	ast)				ļ	·	rst, Middle, M	laiden Surna	ame)	
ylan		Darby Lee 19a. Informant's Name/Relationshi	(Tune Print)		19h Maili	ng Address (Stre		er Mai eror <i>Rumal Ri</i>		City or Town	n, State, Zi	p Code)
Micar nd 2 st nd 2 st lth and 27 is n r traun		Hattie Fields		_		Liber						
Ore, Maryla ges 1 and 2 should tof Health and Men If item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		20b. F	Place of Disponentery, cre	osition (Name of ematory or other p	lace)	Date	2	20c. Location	ı - City or T	own, State
Saltimor bermit. Pages Department of mportant: If it any injury or o		4 Donation 5 ☐ Other (Sp	ecify)			lawn		7/20/	2010	Wood	ilawn	Md
Baltimory permit. Pages: Department of P Important: If ite any injury or of		21. Signatule of Funeral Service L	censee	, ko	M	2. Name and Add larch F .300 Wa	/H We	st	Bal+i	more.	Md	21215
		23a. Par 1. Enter the disease, or o shock, or heart/alure. List o	omplications that cau	sed the deat	th. Do not er	ter the mode of o	lying, such as	ave, s cardiac or re	espiratory arre	st,	na	Approximate Interval Between
Physician		Immedia e Cause (Final disease or condition	nlly one cause on eac	IT IIII C.	isch			onyota				Onset and Death
/Medical Examiner		resulting in death)	Due to (or	as a conseq				1 1	1			1
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Outed outed	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
Records, P.O. Box 68/60, Cx	al Ex	resulting in death) Last	Due to (or	as a consec	quence of):							
687 ficate	edical		d									
BOX 6	M/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me pf pregn h 2 □ Feta		□Ectopic pregna	псу				Date of deli Month	ivery Day Year
he deat	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nt at time of		Other (specify)					
1S, P.O. res that the designed by the be detached		Part II. Other significant condition	ns contributing to dea	th but not res	sulting in the	underlying cause	given in Part	I.	23e. Did tob	acco use co	ontribute to	the cause of death?
cords **requires been sign should be	ed by								1 □ Ye	es 2∏No	3 □ Pr	obably 4 Unknown
Vital Records, sician: The law requires the certificate has been signe rector, page 2 should be d	Completed								24a. Was a autops perfori	SV V	b. Were au prior to death?	itopsy findings available completion of cause of
or Vital Rec Physician: The lav this certificate has al director, page 2							OC Disc	as of Dooth //		2 No	1 ☐ Yes	2□ No
Vitarisiciarisicialis certificialis	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ In	patient 2	☐ ER/Outpati	ent 3 DOA	Other		5 ☐ Reside		Other (Spe	cify)
Division or Vital or Attending Physician; after death. Director: After this certified in by the funeral director, I	n: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month	Injury , Day Year)	28b. Time Injury		njury at Vork?		d. Describe ho	ow injury occ	curred	
SiOI tendir leath. tor: Al	catic	2 Accident investig 3 Suicide 6 Could n	ation ot be 280 Place of	if injuny - At h	nome farm s	M street, factory, off	Yes 2		f. Location (Si	treet and Nu	ımber or Ri	ural Route Number,
Divi	Certification:	4 ☐ Homicide determi		g, etc. (Spec		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tow	n, State)		
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the base Examiner: On the base and manne	sis of examin	nowledge, de nation and/or	ath occurred at the investigation, in a	e time, date ny opinion, d	and place, an eath occurred	d due to the o	ause(s) and date and plac	l manner as ce, and du	s stated. e to the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier				29c. Lic	ense number					th, Day, Year)
* (30. Name and address of person	who comple	of death (Ite	em 23a) (Typ	e, Print)	,		0	3-9		2010 D 21209
Y)		Jef ZIV	rell (M)	5.5	335	Smith	Av	<u> </u>	Balti	mere	W	60212 0
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Amend Items 23aPt11,25 per me,8905,07/15/2010din Mental Hygiene 0 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 26 Physician/ 35 SCOTT ROYSON 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MAKYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday Funeral 1 🔀 M 2 🗆 F Hours 05/06/1959 51 Maryland 220-72-3620 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🛛 No Baltimore Catonsville Maryland 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? ō Funeral 23a United States 21228 5736 Calverton Road items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give ö ₽ Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced "natural", Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Mechanic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file ၉ Gloria Gough Roy Royson other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2640 West Park Drive Baltimore, Maryland 21207 Gloria Royson - Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 06/28/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Dayld J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 21. Signature of Funeral Service Licensee nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Part . Enter the disease, or co Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COMPLICATIONS OF END STATE LIVER DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HRONIC HERATT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER and burial-tran Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical that the death certificate be Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No certificate Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA After this completed filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1881919330 6/26/2010

DHMH 17 Rev 7/2009

State

Registrar

Dougks Corwa

15 2010

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. - L. - Cro-Lin 22 5 GREENE ST N3E09 BALTIMORE MD 21201

32. Registrar's Signature

		For State Registrar	ate of Maryland / Dep Ce	partment of He ertificate of De		al Hygiene Reg. No	ZUIU	22039
Physic	ian/	1. Decedent's Name (First, Middle, Last)	na Pas	2101		e of Death	ay 9 2500	3. Time of Death
Med Exam	dical iner	4a. Facility Name (if not institution, give street		4b. Giby Town, or Le	ocation of Death	1) 40	c. County of Death	forey
Funera Directo		5. Social Security Number 6. Sex 1 □ M 2	7. Age (In yrs. last birthday 78 Yrs.) If Under 1 Year	Hours Min. 8, Dat 01/	te of Birth onth, Day, Year) 25/1932	9. Birth Count	ace (State or Fereign ry) DC
yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Prince Coor	10c. City, Town or I	Location ttsville			10	0d. Inside City Limits
th the Mar 3a or 28a- be notifi	al Director	MD Prince Geor 10e. Street and Number	ges liya	10f. Zip Code		10g. C	itizen of What Coun	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	d by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? Yes 2 No Yes, Give ar or Dates.	20783 3. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☒ No	panic Origin? (Specify Yes Mexican, Puerto Rican, o Specify:	s or No- etc.)	14. Race - America Black, White, e Specity: Black	etc.
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam	Completed	15. Decedent's Educatio (Specify only highest grade con	n 16a. Dec npleted) (Giv Illege (1-4 or 5+)	cedent's Usual Occupative kind of work done dur DO NOT use retired)	ion ring most of working	1	Kind of Business Inc	Office
Aaryland 21 should be filed with and Mental Hygien r is marked other ti	To Be	17. Father's Name (First, Middle, Last) James Harris			18. Mother's Name (First, Mar	Middle, Maiden		
Maryl 2 should lith and Mi 27 is mar		19a. Informant's Name/Relationship (Type, Pri Sr Theodore L Rozier/\$p	· ·		d Number or Rural Route			Code)
Baltimore, Moermit. Page 1 and 2 separtment of Health Important: If Item 27 any injury or other tr.		20a. Method of Disposition 1 □ XBurial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	20b. Place of Dis	sposition (Name of rematory or other place)	Date	20c. L	Location - City or To	
Baltimo permit. Page Department of Important: If	ouce.	21. Signature of Funeral Service Licenses	MO1057		^{of Facility} Marsha NW Washing			e
Physician Medic Examine	al	23a Faft 1. Enter the disease, or complication hock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do not e	Heuse à	ait Di	Seas	ی	Approximate Interval Between Onset and Death
60 X ate be execute hysician and the burial-trans	edical Exar	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of):					
Box 687 death certifics he attending p ed for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death ☐ Unknown	3			23d. Date of delive	ery Day Year
S, P.O. ires that the signed by t	d by P	Part II. Other significant conditions contribu	ting to death but not resulting in th	ne underlying cause give	en in Part I. 2		use contribute to the	he cause of death?
Division of Vital Records, tal or Attending Physician: The law requires re after death. In Director. After this certificate has been signed in by the funeral director, page 2 should be						4a. Was an autopsy performed?	prior to co	psy findings available impletion of cause of
/ital /sician: s certifii	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	al: 1 ☐ Inpatient 2 ☐ ER/Outpa	Lout.	ce of Death (Check only on the control of the contr		6 Other (Specify	v)
n of Inding Phy th. After this funeral of		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Ba. Date of injury (Month, Day, Year) 28b. Time injur	e of 28c. Injury y work?	at 28d. D	escribe how inju		
Division of Atterments after dear I Director d in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Lo	ocation (Street a ity or Town, Stat	and Number or Rura te)	l Route Number,
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2:	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: O only one) 3 Certifying Nurse Par	To the best of my knowledge, dea n the basis of examination and/or in ctioner: To the best of my knowledge	vestigation, in my opinion	 death occurred at the tir 	ne. date and plac	ce, and due to the ca	ause(s) and manner stated.
To the within To the com		29b. Signature and title of certifier	fectbel my	29c. License	3647J	29d. E	Date signed (Month,	Day, Year)
5		30. Name and address of person who comple James Rosenthal 2001	O Century Blvd		Germantown N	MD 2087	4	
S Regis	tate strar	31. Date filed (Month, Day, Year) JUL 1520	32. Registar's Signature	fall				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22040 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Janet Yvonne Shreve 12:40 p M July 13, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216_30-5414 Months 1 □ M 2 🗓 F 74 Director West Virginia 09/28/1935 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanther must be notified at Anne Arundel Glen Burnie MD **Funeral Director** 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7466 E. Furnace Branch Road 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2XXNo Specify: White Completed by If Yes Give Specify 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Analyst Financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Inter the Interest of the Interest of the Interest of the Interest of Inte Elsworth Vance Kinney Addie Obestin Freeman 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Galvin / Daughter 2304 231st St., Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 07/15/2010 Brooklyn Park, MD 5 ☐ Other (Specify) 21. Signature of 22. Name and Address of Facility
Bailey Funeral Home and Cremation Service, PA M01452 4023 Annapolis Road, Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi c or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** ronar embolu disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to in innertial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and of in by the funeral director, age 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live birth 2 Fetal death 4 Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28h Time of 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated

State Registrar

enniter Date filed (Month, Day,

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29d. Date signed (Mpnth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

		_	For State of Ma	-	Department of F Certificate of L		Reg.	2010	22041
	Physicia Medic		Decedent's Name (First, Middle, Last) Canda	ce M.	Smith	2	2. Date of Death Month	Day 2010	3. Time of Death 7:30 P M
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مر	Funeral		Gilchrist Center 5. Social Security Number 6. Sex 7. Age	(In yrs. last birth	Towsor	If Under 24 Hrs. 8	. Date of Birth	Balto g. Bir	thplace (State or Foreign
	Director		068-82-8802 1 ☐ M 2 X F Usual Residence of Decedent	35 Y	rs. Months Days	Hours Min.	(Month, Day, Yea 5-7-19	75 <u> </u>	iberia
	aryland a-f show fied at	ctor	10a. State 10b. County MD na	10c. City, Town	or Location				10d. Inside City Limits 1 X Yes 2 □ No
	the Ma or 28% e notii	l Dire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	
	th with ns 23a must t	ınera	3222 Elmora Avenue		21213			J S A	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Exammed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates.		13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ▼ No	in, Mexican, Puerto Ric	g resion No- can, etc.)	14. Race - Ame Black, Whit	
5-0	72 hour matu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	I	Decedent's Usual Occup (Give kind of work done of	ation during most of working	168	. Kind of Business	Industry
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pu	e filed vertal Hyge of othe	To Be	17. Father's Name (First, Middle, Last) Toby A. Gbeh			18. Mother's Name (F Esther	First, Middle, Maid	en Surname) Mark	
Maryland 21215-0036	nould bund Mer marker marker	[19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Street		loute Number, City		p Code)
Σ̈́	nd 2 sk lealth a m 27 is ner tra		Otis Smith-Husband	32	222 Elmora	Avenue	Baltimo	re, MD	21213
nore	age 1 a ant of H it: If ite y or otl		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery	Disposition (Name of y, crematory or other place			Location - City or	
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Ω	9 9 E E 6	6 37	ign Clata	the death Death		North A		Balto,	MD 21202
	hysician/	5 /	23a. Part 1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final	7950L 1		g, such as cardiac or n	espiratory arrest,		Approximate Interval Between Onset and Death
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b -	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events c.						
~	cate be executed physician and s the burial-transit	cal E	resulting in death) Last Due to (or as a	consequence of	t):				
3760		Medical	IF FEMALE:						
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \[\text{Vas} \] 23c. If yes, outcome of the past 12 months? 4 \[\text{Pregnant at} \]	Fetal death	3 Ectopic pregnand 5 Other (specify)	су		23d. Date of de Month	livery Day Year
о В	it the de by the	Phys	g Unknown 9 Unknown Part II. Other significant conditions contributing to death but	ut not reculting in	the underlying cause give	ven in Port I	One Didashees	a voa eestribute te	o the cause of death?
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Be	n: The I ficate h rr, page		25. Was case referred to medical		00.00	(D. N. (C)	performed	? death? No 1 ☐ Ye	s 2 🗆 No
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Division of Vital Records,	Attencer deatlector: by the	Certificate:	2' Accident Investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined 28e. Place of Injurbuilding, etc.		M 1 □ m, street, factory, office		f. Location (Street City or Town, St	and Number or Ru	ıral Route Number,
Š	pital or burs aft eral Dir filled in				leath accurad at the time	date and place and s			ated
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	To the Control of the		29b. Signature and title of certifier		29c. Licenso			Date signed (Mont	
	5		30. Name and address of person who completed cause of de	ath (Item 23a) (T	vne. Print)	4315		ULY 121	2010
	8		JANIEUE DOBERMAN, MIS 670	1 NCHAR	2158 ST, 8H1	TE 4105	BALTIMIT	DE, MD.	21204
ı	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	.0.0				

State of Maryland / Department of Health and Mental Hygien 20 10 1 1 - State Registrar State of Maryland / Department of Health and Mental Hygien 20 10 10 me, 2905,07,14/2010dhb Reg. No. 22042 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician SAUNDERS 2010 MA GRACE /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltimore

Baltimore

Grant If Under 24 Hrs. Good Samaritan Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🕇 F Months Davs Hours Maryland June 17,1929 80 216-24-5658 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ir than "natural", or items 23a or 28a-f shov tre Medical Examinar must be notified at 1 ☐Yes 2 ☑ No Director Md. Balto. Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 10012 Nearbrook Lane by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveA Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any Injury or other traumatic event, tra Medical Exartina 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Antoinette Martino Saverio Esposito ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8014 Redstone Road Kingsville, Md. 21087 Martin A. Saunders Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 5-15-2010 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugle Service Lig 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Subdurns **Physician** He ma Tomas mo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
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1 A Yes 26. Place of Death (Check only one) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of Injury
Unknown 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Accident 5 Pending investigation Multiple falls 1 ☐ Yes 2 XNo ours after death.

neral Director: A
rilled in by the ft Unknown 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Found: 10012 Near-brook Lane, Par kville, MD 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Found: Home 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier GOOD Samaritan Hosp. Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EFFRE PICCING 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 22043 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:21 p M Mic 2010 /Medical Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Agnes Baltimore Hospita 7. Age (In yrs. last birthday) If Under 1 Year [If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1 NM 2 | F Months Days Hours Min 219-26-4480 Georgia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exprairms is ust be retified at Funeral Director 1 Yes 2 No timore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 ILSA 1mmi 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □ Yes 2 □ No Specify ģ Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Summi+ Ave Baltimore Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Balto MOZIZO Heigh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardion or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiogenic Shock Immediate Cause (Final **Physician** 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner schemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed Failure and burial-tran Due to (or as a consequence of) P.O. Box 68760. the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been signe Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Ischemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Vital 2X No 2 X No 1 🗆 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient Certification: To 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pendina 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AS2438S284348 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 900 Bani lurad 31. Date filed (Month, Day, Year, State 32. Registrar's ignature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25,28d,e.perME,6965,sure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SR Month /1 Physician/ 912 DI 8 heodore Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of De Examiner ARITIMORE MORR Ins OPKIL ayliew 06 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Funeral Months Days Hours (Month, Day, Year Country)
MARYLAND 62 1948 Director 216-50-0621 Usual Residence of Decedent items 23a or 28a-f show er must be notified at 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland 10c City Town or Location Director 1 ☐ Yes 2 🕅 No DUNDALK MARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21222 U.S.A. 1 SOUTH LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status "natural", or iter edical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: If Yes, Give Year or Dates Specify: BLACK 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. tant: If item 27 is marked other tha ury or other traumatic event, the N SPARROWS POINT 12th grade ASSEMBLY LINE WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ YOUNG SIMMS RUBY THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the Theodore Sims Jr./ Son <u> 1001 Kayden Ln., </u> Baltimore, Md., 21221 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 07-16-2010 BALTIMORE, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE, BALTIMORE, MD 21217 21. Si matere of Funeral Service Licensee Ulas Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cauph disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner UMatic Steffing of the Property of Manual Property of the Steffing of Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last 0 The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month 5 Other (specify) been signed by the a should be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No page 2 1 Yes 2 W or Attending Physician; director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury 28b. Time of 28c Other: 1 X Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28c. Injury at work?

1 ☐ Yes 2 No 28d. Describe how injury occurre Subject pedestrian (Manth, Day, Year) injury injury 1 Natural 2 Accident 5 Pending s after death. struck by car Investigation filled in by the 28e. I lace of Injury - At home, farm, street, far uilding, etc. (*) esify) Suicide Could not be 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 6400 Alk City or To Highway within 24 hours a Medical il Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 2010 3850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ohh 31. Date filed (Month, Day, Year) 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 10b,c,e,f, per fh,9905,07/15/2010dhb,19a Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Day Physician/ 2010 6:00 AM M Cecil E. Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1218 Cedar Corner Road Ceci] Perryville 9. Birthplace (State or Foreign Country) Maryland Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe Age (In vrs. last birthday **Funeral** 1 X M 2 □ F Days Min. Months Hours 07/18/1941 68 Director 213-38-9210 Usual Residence of Decedent 10d. Inside City Limits 10a. State Ceci1 10c. City, Town or Location within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No 28a-f Bel Air Perryville MD Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 1218 Cedar Corner Road Funeral 23a 21903 21015 U.S.A. Plumtree Road items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify.White Completed 3 Divorced 4 Divorced Year or Dates.Vietnam Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Welder Koppers Co. permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin W. Smith Mae Iris Cullen 19a. Informant's Name/Relationship (Type, Print) brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1142 Priestford Road - Street, Maryland 21154 John W. Smith 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 07/13/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21087 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Melanona nset and Death Immediate Cause (Final nan etas Ph sician/ IN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death Yes 1 Yes 2 L g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No Yes 124 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Nesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the signed (Month, Day, Year) 29b. Signature and title ρ 2010

State Registrar 30. Name and address

31. Date filed (N

Registrar's Sig

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AMEND ITEM#29a, 30perDVR, G905, 7/15/2010, WS
State of Maryland / Department of Health and Mental Hygiene
AMEND ITEM#20b,perFH, #20perCNP, G905, 7/15/2010, WS
Certificate of Death
Reg. No. 22046 For State Registrar Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY 10 2ďľ0 3:17P м SCHEINKER ELAINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BEST CARE ASSISTED LIVING REISTERSTOWN Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) NC 1 🗆 M 2 💢 F Months Days Hours 0870571924 85 Yrs. Director 219-10-0042 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits death with the Maryland 10c. City, Town or Location Director 1 Yes 2 X No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21136 639 MAIN STREET 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) REPRESENTATIVE TELESERVICE SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GALVIN KATIE В APPLEBAUM SAMUEL М 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3925 CHAFFEY ROAD, RANDALLSTOWN, MD 21133 SANDRA SCHEINKER / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Ath 1944), crement WA pher place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State $07/\frac{12}{12}/2010$ BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) AITZ CHAIM CONG. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 ure of Funeral Service License 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final men Physician e 611 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or a consequence of) cause. Enter Underlying the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day signed by the a 9 Unknov Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 1 Yes 2 No 2 🕽 the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? **ASSISTED** To Hospital: Other: 1 🗌 Yes rsing Home 5 🗆 Residence 6 ื Other (Specify**) ivino** 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1, 2 Natural 2 Accider injury 5 Pending 2 🗌 No Accident Investigation within 24 hours after deati To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the time cause(s) and due to the cause(s) and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q Reisterstown, MD <u>Augustina Opeewe</u> Care Assisted Living 31. Date filed (Month, Day, Year) 152010 Registrar

The part of the property of the part of th	10-05234 Robert Sebeck	Please Type or Print in Black Inde	elible Ink. Ensure All Copies Are L nent of Health and Mental Hygiene	
Physician Involce Examiner Robert Sebeck As Peacly Name prior elegancy reserved and survey Johns Hopkins Baywaw Medical Center Function Provided Treatment of the Serve Sebeck As Peacly Name prior elegancy reserved and survey Johns Hopkins Baywaw Medical Center Ballonce Ballonce	Nobell Gebear	1- For State Certific	cate of Death	2010 22047
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Johns Hopkins Baylow Medical Center 212-48-6209 (X.M. 1) = A 49 49 49 49 49 40 10 10 10 10 10 10 10 10 10 10 10 10 10	Medical Examine	ROBELE BEBEEK	July 12,	2010 2115 hrs
5 Social Sicurity Number 0. See 1. Age (in yes and birthology 1. Age 1. Age				4c. County of Death
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Md. Harford Abingdon Total Steel and Number		Usual Residence of Decedent		
To Street and Number To Street and Number	w any			10d. Inside City Limits 1 Yes 2 No
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29d. Date signed (Month, Day 29d. Date signed	n of ling Pl After funera	27. Manner of Death 28a. Date of Injury 28b	Subject fe	
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29d. Date signed (Month, Day 29d. Date signed	Divi	3 Suicide 6 Could not be determined (Specify) Townhouse / F	or Town	State)
29d. Date signed (Month, Day 29d. Date signed	Hospi 24 hou Funer		leath occurred at the time, date and place, and due to the ca	use(s) and manner as stated.
29d. Date signed (Month, Day 29d. Date signed	o the vithin 2 or the omplet	one) 2 Medical Examiner: On the basis of examination and/or and manner stated	r investigation, in my opinion, death occurred at the time, dat	te and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Jagistrar's Signature	F S F S	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Fagistrar's Signature 32. Fagistrar's Signature 33. Date filed (Month, Day, Year) 33. Fagistrar's Signature 33. Date filed (Month, Day, Year) 33. Fagistrar's Signature 33. Date filed (Month, Day, Year) 33. Date filed	.11	(almn	Δ	July 13, 2010
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 16:40 M Month Physician/ Herman L. Schwartz Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Feb. 20 Months Hours ^{Year}1921_ 1 🔀 M 2 🗆 F Maryland 219-18-1167 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at 10a, State Director 28a-f 1 Yes XNo <u>Maryland</u> Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number items 23a or ner must be n Funeral United States 21014 203 Burkwood Court Apt K. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ò 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White "natural" 3 Divorced 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State Highway Admin 10 Cartographer n and Mental Hygier 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fi Health and Mental ပ္ 27 is marked r traumatic e Mollie Pecker Frank Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 Wheeler Drive Suffield, CT 06093 Frank A. Schwartz / Son Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 5 Evans Funeral Chapel 1 Burial 2 Cremation 3 Removal from State 7/13/2010 Forest Hill, MD 4 Donation 5 Other (Specify) Bel 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-BelAir
3 Newport Drive Forest Hill, MD 21050 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death Immediate Cause (Final intre cerebra Physician/ pontaneou disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner MOMICECM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last HOL and the burial-tran Due to (or as a consequence of) physician Physician/Medical as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Records, Hospital or Attending Physician: The law requires 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 **X**No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending s after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours a Medical 1 Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPPOR Chasa reako IAN 31. Date filed (Month, Day, State Registrar

2010

			1 - For Amend Item	23atter	f Maryla pr dr.	nd Depi	377F372 tificate	2616 of D	alth ar eath	nd M	ental Hy	giene Reg. No		10	22049
			1. Decedent's Name (First, Middle,	Last)							2. Date of De	aath Day	,	Year	3. Time of Death
	Physici /Medi		Pearl E. Sr	nith							June 2		010		12:15 PM
E	Examir		4a. Facility Name (If not institution,				4b. City, To			Death		4c.	County	of Death	
			Keswick Mu			- In an include of a col	If Under 1		Lmore	Hrs	9 Data =4 G			0.0:45	1 (0
	Funeral Director		279-14-6844	6. Sex 1 □ M 2 ☑ F	7. Age (in yrs	s. last birthday) 9 Yrs.		Days		Min.	8. Date of Bir (Month, Da Mar 11	Year)	21	9. Birting Cour Oh	place (State or Foreign ntry) 10
	MG T		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	cation							1	0d. Inside City Limits
	Mary	ō	MD			Baltin	nore								1√2 Yes 2 □ No
	the 28a	rec	10e. Street and Number			Darta	10f. Zip Co	ode				10g. Cit	izen of	What Cour	ntry?
	h with	O E	700 W. 40th St	reet #2	17			212	11			Į	JSA		
	deat	ner	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Deceden	t of Hisp	panic Origin	n? (Spe	cify Yes or No	o-		ce - Americ	
21215-0036	within 72 hours after death with the Marylend ane, than "natural", or Iteme 23a or 28a-f ehow he Medical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced		2 (Ž)No ive		1 □ Yes 2√X		Specify:		110411, 0(0.)		Specif		ite
9-0	72 ho	ted	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual C	Occupati	ion	of worker	10	16b. K	ind of B	usiness/In	dustry
21	thin 7	p le	Elementary/Secondary (0-12)	Ť	1-4or 5+)	life.	DO NOT use	retired)	ing most c	n workii	·9				
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Ind	be fill d ott	Be	17. Father's Name (First, Middle, L					1			(First, Middle			ne)	
<u>\</u>	ould be in Mental I warked o	ç	Walton Mosses			1000					Estell				
Maryland	d 2 st th and 7 te m treum		19a. Informant's Name/Relationsh Patricia Goldh		hter		ng Address (S Pamona							. State, Zip 21209	(Code)
	1 and Health em 27		20a. Method of Disposition			Place of Dispo	sition (Name	of	1		ate			- City or To	own. State
3altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28a-f show with jointry or other treumatic avent, the Medical Examinat must be notified at ADGS.		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (Sp		1	cemetery, crei	natory`or othe	er place)) 					,	
Balt	permit. Departr Import. eny Inj.		21. Signature of Pineral Service L Zaniel A	Naylot	6		Name and A tate A Baltimo		_			Г. Ва	lti:	more	Street
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the dea							arrest.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	10		to the	ine							1	Onset and Death
	/Medical		resulting in death)	Due to	(or as a conse	equence of):									,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Examiner		Conventially list conditions	End	Stage A	Atheros	clerot	ic (Cardio	ovas	cular	Dise	ase		Years
	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conse	equence of):									
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9	death certifica attending ph d for use as ti		IF FEMALE:	23c If yes ou	tcome of preg	nancy							004 D-		
Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live	birth 2 Fe nant at time of	tal death 3[Ectopic preg							ate of delive onth	Day Year
P.O.	y the d	ysic	1 □ Yes 2 ☎No 9 □ Unknown	9□ Unkr		J	J Other (speci	"",							
	Physician: The law requires that the death certificate has been signed by the attending or this certificate has been signed by the attending rail director, page 2 should be detached for use as	y P	Part II. Other significant condition	s contributing to c	leath but not re	esulting in the u	nderlying cau:	se given	in Part I.		23e. Did	tobacco	use con	tribute to t	he cause of death?
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Division	or Attendater death Director:	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Place	e of Injury - At ling, etc. (Spec	home, farm, sti	eet, factory, o	office		2	28f. Location City or To			ber or Rura	al Route Number,
	ral D	Se													
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Vertifying (Check only 2 Medical E	Physician: To the teaminer: On the teaminer and mar	e best of my kr pasis of examinated.	nowledge, deat nation and/or in	h occurred at vestigation, in	the time my opir	, date and nion, death	place, a occurre	and due to the ed at the time	cause(s , date an) and m d place,	anner as s and due to	tated. o the cause(s)
	Nithin Fo th	Me	29b. Signature and title of certifier				29c. L	icense i	number				-		Day, Year)
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-	2		30. Name and address of person v	-						3023	NATRE	ורטי	021	211	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010 22050 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary J. Stoots 2010 8:15 A July 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday Days Hours 1 □ M 2 🔀 F Months Min. (Month, Day, Year) -8-1938 9 212-36-2597 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8802 Wilson Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: White If Yes Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Lambdin Edward Smith Limerick 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8802 Wilson Avenue, Baltimore, MD 21234 <u>Donna Stoots - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-17-10 Baltimore, Oak Lawn Cemetery 21. Signature of Funeral Ser Bradley-Ashton Funeral Home Willow Spring Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death NNO Cance YLACS resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 1 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Physician. Medical Examiner Examiner

Physician/

Medical

Director

Funeral

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ural", or items 23a or 28a-f show Examiner must be notified at

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permit. Page 1 and 2 sh Department of Health a Important: If item 27 is

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Maryland 21215-0036

Baltimore,

burial-tran physician that the death certificate be nse for detached signed by be det has page 2 certificate

Physician/Medical

Completed by

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Certificate:

Medical

Box 68760 P.O. Records, The law requires To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Division of Vital

State Registrar

30. Name and

3 Suicide 4 Homicide

29a. Certifier

(Check

only one

29b. Signature and title of certifier

determined

completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my anisis

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9 2010 9:20 AM Elizabeth K. Schaefer July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Care Rossville Baltimore Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 84 1-24-1926 Director Iowa <u>483-20-3179</u> Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Dundalk the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 65 Admiral Blvd. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 TkNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify SpecifyWhite à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Childcare Nanny traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Keleher Ellen Keleher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a Admiral Blvd., Dundalk, MD 21222

Date 20c. Location - City or Town, State permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Kerrie Kalb - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7-13-10 Baltimore, MD 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home 2134 Willow Spring Road. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UNG CANGER **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) ned by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, ertifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060530

State Registrar

31. Date filed (Month, Day, Year)

poleted cause of death (Item 23a) (Type, Print)

POL 9106, PA ILADELPHIA PD # 208, BALTIMURE, MD 21237

32 Benistrar's Signature

JUL 152010



DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 | 0 22052 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 3:30 A^M Barbara Ann Schult June 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 XF 333-38-5067 62 Director 09/18/1947 Illinois Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits al Hygiene, cither then "natural", or fleme 23a or 28a-f ehow vent, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No MD Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Locust Court 21904 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be as 1 end 2 should be fi of Health and Mental H item 27 te marked of William Schult Elizabeth Cielieski ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angeline Gunter / Daughter 5 Locust Court, Port Deposit, MD 21904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Peges 1
Department of H
Important: If its
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 06/24/2010 Hanover, Maryland 21. Signature of Funeral Service Consee SUSERY L. CANDY 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 M00018 A. Errier the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, if heart failure lost only one cause on each line. Approximate Interval Between Imperiate Cause (Final discusse or condition resulting in death) Onset and Death **Physician** SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner and I-transit Due to (or as a consequence of) signed by the attending physician at be detached for use as the burial Completed by Physician/Medical Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page 2 s 24a. Was an 27 No 1 Yes 2 No of Vital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident thin 24 hours efter deat the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death conursed at the time, date and clane, and due to the nause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0069118 30. Name and address of pason who completed cause of death (Item 23a) (Type, Print UNLOWAVE Kuth Awala MD 501 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

BARBARA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JULY Month 2010 6:55 p M JAMES WILLIAM THOMAS Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FUTURECARE (SETON) 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birtnp... Country) MD **Funeral** Min APR. 17, 1933 1 🕱 M 2 🗆 F Months Days Hours Director 213-30-4040 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No MD BALTIMORE 10e, Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? "natural", or items 23a o Funeral USA 2906 W. COLD SPRING LA. 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ð 2 🗆 No Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Derartment of Health and Mental Hygiene.
Im, ortant: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CITY of BALTIMORE 12TH CUSTODIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LINDSAY THOMAS EVELYN PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY THOMAS/WIFE 2906 W. COLD SPRING LA., BALTIMORE, MD 21215 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALATIMORE NATIONAL 07/08/2010 | CATONSVILLE, MD 21. Signature of Funeral Service I 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD 23a. Part 1. Enter the disea shock, or heart failur complications that cau the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between only one cause on each line Immediate Cause (Final Physician/ archnorum disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Be Completed by Physician/Medical Dusela Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) g 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyperlen from 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

Funeral Director. After this certificate has leted filled in by the funeral director, page 2 s autopsy performed 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 1 No Certificate: To 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 \square Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours aff To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier D 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW ST Smile 308 BALTIMORE MD 21291 SHOALBA. HASHMIMD. 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:15AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayuleus Medical (lente timor 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Davs MA Director Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 ☐ No More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sur မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (1417 Alice Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) eisterstawn 21. Si vature Fu eral Service Licens Tuneral Homes CTL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a. NON-KCHEMIC Cardiomyopath disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Dulseluss of Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ this certificate has been signed by the atterral director, page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certification in by the funeral director, it 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tyes 2 **N**No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 1 X-Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Fxaminer On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completed (Check Curtifying Nurse urred at the time, date and lace, and due to the cause's and manner as stated 29b. Signature and title of certifier 29c. License number of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1:56 P.M. am nomas 2010 4c. County of Death me (If not ins tution, give street and number, 4b. City, Town, or Location of Death agnes are altimore cal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, You March 21 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Min 1 M 2 □ F -62-667 Yrs March Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No TIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 400 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 Widowed 4 Divorced B last 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) played OWIN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OFDW n nomas 19a. Informant's Name/Relationship (Type. Print) (Briter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road 3801 Balto. raington . Dammon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cathedral Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licen Alle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death atherosclerotic Cardio vascula Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

and

the attending physician thed for use as the burial

signed by

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certificate

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After

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othe howithin 2/

or Attending

director.

the Director:

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Completed

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Certification: To

Medical

the

The law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

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Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

. Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 Is marked oth

= 5 permit. Pages Department o Important: If any Injury or once.

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Examiner Physician/Medical IF FEMALE:

23b. Was decedent pregnant in the past 12 months? □Yes 2□No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy performed

24a. Was an 20 No 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \)

1 ☐ Yes

exa	aminer's		ω	meulcai
16	Yes	2 🗌 No		
27. Ma	nner of	Death		

Natural 2 Accident 5 Pending investigation 6 Could not be determined Date of Injury (Month, Day, Year)

1 Inpatient

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 ☐ Yes

28d. Describe how injury occurred 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

MI

29c. License number

2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

Scaton Ave Mason 900 Tonya

Baltimore Mi)

State Registrar 31. Date filed (Month, Day, Year) 15



		1 - For State Registrar State Registrar State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of D	eath	22056 3. Time of Death
Physic		Benjamin F. Whitaker, Jr.	Month July	Day Year	11:020 M
/Med Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Do		4c. County of Dea	
Exam	iici		4.0	Bactin	coe
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Irs. 8. Date of B	irth 9. Bir	rthplace (State or Foreign ountry)
Directo	r	215-66-2054 57 Yrs.		-	lo Carolina
pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
aryla shov	5	Deltimore			1 X Yes 2 □ No
he M 28a-f	Director	Ivial yialia		10g. Citizen of What C	ountry?
with t				U.S	
eath rs 23	era	2011110010171101100	? (Specify Yes or N		
faryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Sive X Year or Dates: 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Policy Specify: 1 Yes 2 No Specify:	uerto Rican, etc.)	Black, Whi	te, etc. Black
2 hou	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	working	16b. Kind of Business	s/Industry
215 Bin 7	宣	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	Working	Self Fi	mployed
21 Signary Sig	၂	Truck Driver			
nd be file tal Hy d oth	a	17. Father's Name (First, Middle, Last) 18. Mother's		le, Maiden Surname)	
yla buld to Men arke	2	Benjamin F. Whitaker		Etta Whitaker	
Maryland d 2 should be file th and Mental Hy T is marked oth		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number o			Zip Code)
re, Mass 1 and 2 of Health sitem 27 is	-	Freddie Whitaker 2311 Ruskin Avenue Balt	Date	20c. Location - City o	r Town State
Baltimore, In permit. Pages 1 and Department of Healt Important: If item 27 any injury or other t		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)			
timen trant: Jury		4 Donation 5 Other (Specify) Loudon Park Cemetery	07/13/10	Baltimo	ore, Md.
Ball Dermit Depar mpor		21. Signature of Foneral Service Licensee 22. Name and Address of Facility	naral Candac	D A	
	2	Estep Brothers Fu 1300 Eutaw Place 23a. Pht1. Enter the disease, or complications that our ed the death. Do not enter the mode of dying, such as care	Baltimore, N	ใช 21217	Approximate
		Show, Careat failure. List only one cause on earning.	rdiac or respiratory	arrest,	Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition a.			
/Medica		resulting in death) Due to (or as a consequence of):			
- Adminio		Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			-
D tis	ie e	Cause (Disease or injury			
760, CE to be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
'60	<u>e</u>				
68760, 4 tificate be executed ag physician and as the burial-transit	edical	d			
Box (eath certi	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of d	elivery
Box death cer attendir	Physician/M	in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.O. at the de lby the atached	ysi	9 Unknown			
b, P.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Die	d tobacco use contribute	to the cause of death?
rds, quires n sign	d by		_ 10]Yes 2 ☐ No 3 ☐	Probably 42 Unknown
cord w requir	Completed		24a. Wa		autopsy findings available
Re la	l Ĕ		l pe	rformed? death?	o completion of cause of es 2 No
Vital Fictar: The certificate ector, pag		25. Was case referred to medical 26. Place of	Death (Check only		2 2 1 1 1 0
f Vital Royslclan: The list certificate hadirector, page	o Be	examiner? Other:		esidence 6 Other (S)	pecify)
Division of Vital Records, or attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		e how injury occurred	
on odling lath.	iğ.	1 Matural 5 Pending (Month, Ďay, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
Atter r dea sector	iji	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At home, farm, street, factory, office	28f. Location	(Street and Number or fown, State)	Rural Route Number,
Spital or Attendinours after death.	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City of 1	own, state)	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and provided in the control of the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to to occurred at the time	he cause(s) and manner ne, date and place, and d	as stated. ue to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
		Cleybleren D2908	5	JUL7 6	2010
A		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Roca		55115
S	tate	31. Date filed (Month, Day, Year) 32. Rigistrar's Signature			V
Regis	trar	31. Date filed (Month, Day, Year) 32. Figistrar's Signature JUL 152010 Signature			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amond#9_PerFHPCC7-2-10cm Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2<u>010</u> Month Physician/ Ekhssabet Antoun 16:21PM 21 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville Shady Grove Hospital 5. Social Security Number 8. Date of Birth (Month, Day, Yea May 28, 9. Birthplace (State or Foreign Country) Lebanon 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. 1 🗆 M 2 🛛 F Hours 097-753896 80 Director Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director MD Montgomery Rockville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a or edical Examiner must be 23a 7209 Wapello Drive Funeral 20855 Lebanon death with 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes If Yes, Give filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2121 1 and 2 should be filed within 7: of Health and Mental Hygiene. I item 27 is marked other than other traumatic event, the ME. Elementary/Seconday (0-12) College (1-4 or 5+) Self Domestic Unknown Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hana Antoun Sarkes Antoun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 7209 Wapello Drive Rockville MD 20855 Harry Pamboukian / Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 06/25/10 Silver Spring, MD Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 20019 Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn&Sons 5635 Eads St. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Ccnqcs+1~c Heart disease or condition resulting in death) Medical Examiner 210 ~620 Sequentially list conditions, if any, reading to infraedate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director After this certificate has been signed by the attending physician and FENDICA for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial direare Physician/Medical arters cycha. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျင 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending injury Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifie X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier antimo 29c, License number 29d. Date signed (Month, Day, Year) DA1185 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) accompations was 50812 Docteri 19529 State Registrar

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d	Medi Examir		4a. Facility Name (if not institution,	give street and number			4b. City, Town,				4c. Co	ounty of Death	1
	1		Shady Grove Adv				Rockvi		0/11			tgomer	
	Funeral Director		5. Social Security Number 540-30-3951 Usual Residence of Decedent	3. Sex 1 □ M 2 🔼 F	Age (In yrs. Ia 80		If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Bir May 10	rth ay, Year) 193	9. Birth O Cana	hplace (State or Foreigi Intry) ada
	th the Maryland 3a or 28a-f show t be notified at	rector	10a. State 10b. County Maryland Montgon	nery	10c. City Derv	Town or Loc	ation						10d. Inside City Limits
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 7508 Dew Wood Dr	rive			10f. Zip Code 2085	3			10g. Citize	n of What Cou USA	-
9036	2 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at	ted by Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? ĀNo	If	/as Decedent of I Yes, specify Cub X Yes 2 No			ify Yes or No- lican, etc.)		. Race - Amer Black, White ec <i>ify:</i> Wh	
Maryland 21215-0036	e filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	e Completed by	15. Decedent (Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 c	or 5+)	(Give k	ent's Usual Occu ind of work done ONOT use retired Countant	during mo	st of workin	g		of Business II	ndustry rernment
Vland	should be filed and Mental Hy is marked ott raumatic even	To Be	17. Father's Name (First, Middle, La Harry Smith	st)					her's Name ys Ti	(First, Middle, erney	, Maiden Sur	rname)	
Man	1 and 2 should by of Health and Mer i item 27 is marker other traumatic		19a. Informant's Name/Relationship John Buchanan /			1	g Address (Street Dew Wood					, , ,	Code) 20853
Baltimore.	Page 1 ar nent of He int: If iten		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		to ce	metery, crem	ition (Name of atory or other pla matory	ice)		-2010	1	tion - City or Tater,	Town, State Maryland
Balti	permit. Page 1 a Department of I Important: If ite any injury or of	o a	21. Signature of Funeral Service Lice	ensee			Name and Addre						al Nome MD 21037
	Physician Medical Examiner	6 (4	23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each l	line.	ABDOM	the mode of dyi			respiratory a	rrest,	3	Approximate Interval Between Onset and Death
000		Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or a	UODEA as a conseque	erice of;:	PERFOR	ATION) ————————————————————————————————————				l week
. Box 68760	e de the	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birt 4 Pregnan 9 Unknow	h 2□ Fetal t at time of de	death 3 🗌	Ectopic pregnan Other (specify)	cy			230	d. Date of delive	very Day Year
s. P.O.	ires that the signed by	ا ۾	Part II. Other significant condition	s contributing to death	n but not resu	Ilting in the ur	derlying cause g	iven in Par	t I.		,		the cause of death?
Records,	he law requ tte has beer age 2 shoul	Completed								24a. Was auto perfo		prior to co death?	opsy findings available ompletion of cause of
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l of V	ing Phys rfter this c	ate: To	1 ☐ Yes 2 🔀 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending	1 Inpa	atient 2 🗆 8 njury 2 Day, Year) 2	ER/Outpatient 28b. Time of injury	3 □ DOA 28c. Inju	4 ∐ N ryat k?	28	ne 5 Resi Bd. Describe I		Other (Specif	5y)
Division of Vital	or Attend after death Director: A in by the fi	Sertifica	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of I	njury - At hon etc. (Specify)	ne, farm, stre	M 1 =	Yes 2		8f. Location (S		umber or Rum	al Route Number,
	e Hospital 124 hours a e Funeral L	Medical Certificate:	(Check 2 1 Medical Exa	hysician: To the best aminer: On the basis of turse Practioner: To the	f examination	and/or investi	gation, in my opini	ion, death c	occurred at the	he time, date a	and place, an	d due to the ca	ause(s) and manner stat
	To the within comp	_	29b. Signature and title of sertifier	MD Broc			29c. Licens	e number				igned (Month,	
	1111		30. Name and address of person wh	o completed cause of	f death (Item 2		int)						
1	A+1U Stat	e	TASON BRODSKY 31. Date filed (Month, Day, Year)	32. Regis			ER DRIV	- H	233	Kock	VILLE,	MARY	LAND ZOBS
DI	Registra		JUN 2 8 2	UIU Jane	m p	. pa	Ne -						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 1 0 22060 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Physician/ 10:10 P M Raymond Ersaul Brubeck, JR. 6, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlotte Hall St. Mary's Charlotte Hall Veterans Home 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 √ M 2 □ F 76 Yrs Director June 216-30-4084 Usual Residence of Decedent ms 23a or 28a-f show must be notified at within 72 hours after death with the Maryland 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland ST. Mary's Mechanicsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 39005 Jacqueline Street 20659 United States items 12. Was Decedent Ever in U.S. Arroed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ٥ 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Federal Government Supervisor 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental P ပ Raymond E. Brubeck Ruth Ryder t. Page 1 and 2 should b tment of Health and Mer tant; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Bogan/Niece 3255 Southern Pine Lane, Port Republic, MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important; If it
any injury or o 1 ABurial 2 Cremation 3 Removal from State July 14, Maryland Veterans Cemi. 4 Donation 5 Other (Specify) Cheltenham, MD 2010 of Funeral Service 22. Name and Address of Facility Charlotte Hall, MD 20622. P.A., Ces M008170 PO BOX 128, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line sease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the burial attending physiciar Physician/Medical that the death certificate be P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna Ectopic pregnancy in the past 12 months? ò Month Day Year Pregnant at time of death ed by the a 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 🗌 Yes 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Lecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person Kay Dr. Louis fman, Charlotte Hall, 31. Date filed (Month, State

DHMH 17 Rev 7/2009

Registrar

10-04809

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lary Ernell Butle		St - For State	ate of Marylan	d / Depart	ment of	Health and	d Menta	l Hygiene	20	10	22061
· ·		Registrar 1. Decedent's Name (First, Middl	a Laet)	Certii	ficate of	Deam_		2. Date of De	Reg. No.	13	. Time of Death
Physicia ⊯edical Exami		Mary Ernell	_					Month June 26,	Day Yea		2325 hrs
	and a sub	4a. Facility Name (if not institution	. •	per)	4	b. City, Town, or	Location of I	Death	4c. County		
	est and the	Rt. 235 / St. Johns Ro				Hollywood	. Lizii. dz	2411 To D-t	St. Mary		place (State or
Funeral Director		5. Social Security Number		Age (In yrs. last		If Under 1 Yea Months Days		Min.	Birth(MM/DD/YYYY	Foreign	
Director		214-38-8711 Usual Residence of Decedent	1 M 2 X F	81	Yrs.			05/23	/1929	Coun	^{try)} Maryland
any	ŀ	10a. State 10b. County		10c. City, To	own or Location	on					0d. Inside City Limits
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th the Maryland 23a or 28a-f sho notified at once.	Funeral Director	40412 Medley's				20659			United		
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er dea			1 Yes orced If Yes, Give Year	2 X No	1	Yes 2X No	specify:		Specify:	Blac	· k
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6 72 ho	lete	Elementary/Secondary (0-12)	College (1-4	or 5+)	during mo	ost of working life	. DO NOT us	se retired)			
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	Completed	12			Homema		10.14.11.11	Name (First, Middle	Own Ho		
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e, MD 2 1 and 2 shoul Health and IN item 27 is m		Cynthia E. But	ler/Daughte	er	3315 (Chillum	Rd, #1	03 Hyatt	sville, N	MD 2	0712
		20a. Method of Disposition 1	3 Removal from	l l	ce of Disposi matory or oth	tion (Name of cer er place)	metery,	Date	20c. Location	- City or To	own, State
more Pages 1 nent of H ant: If i		4 Donation 5 Other Sp	pecify:		en of	Peace Ce	em	07/03/201	O Helen,	Mary	/land
Baltimore, permit. Pages 1 at Department of Hee Important: If ite	1	21. ngnature Funeral Service	License		22. N	ame and Address	of Facility	Brinsfiel	d Funeral	1 Hom	e, P.A.
	-1	Edward N. Brin 23a. Part I. Enter the disease, or	sfield, Jr	M00052	2 229	955 Holl	ywood	Road, Led	onardtowi	n. MD	20650 Approximate Interval
Physician Marical		failure. List only one cause	on each line.			o meas or aying,		,	,		Between Onset and Death
Æxaminer		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Blund		162						
	. 1	Sequentially list conditions,	b								
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e executed cian and rial - transit	dical	UNPENDED	dAMENDED		7-				<u> </u>		<u> </u>
760, ficate be g physicia the buri	Med	IF FEMALE:	23c. If yes, out	come of pregnar	ncy	7.00			23d. Date of	f delivery	_
OX 687 eath certific attending p	sician/Me	23b. Was decedent pregnant in the past 12 months?	LIVE DILL	t at time of death		al death 3	Ectopic p	regnancy	Month	Day	y Year
Box 68760, e death certificate be the attending physical for use as the but	sic	1 Yes 2 V No 9 Unl	known 9 Unknown		1 5 Oth	ner (Specify)			1		
O. Entries	Phys	Part II. Other significant condit	ions contributing to d	eath but not resu	ulting in the u	nderlying cause o	given in Part	I. 23e. Did	tobacco use conti	ribute to th	e cause of death?
P. P. rres that signed be de	d by				_			1 Y	es 2 ✓ No 3	Probal	bly 4 Unknown
rds v requi	lete								opsy	prior to cor	psy findings available npletion of cause of
CecC The lay	Completed							per 1 ✓ Yes		death? Yes	2 No
Division of Vital Records, P.O. ral or attending Physician: The law requires that the starter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled.	Bec	25. Was case referred to medica examiner?	(Jessitel -			26.Place	Othor:	heck only one)			
F Vii Physic rr this	2	1 ✓ Yes 2 No 27. Manner of Death			R/Outpatient 8b. Time of Ir		Other ₄ ry at Work?	Nursing Home 5	Residence 6		Scene
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isior Attend or death rector: by the	icat	2 🗸 Accident Inve	stigation 28e Place of	of Injury - At hom	e, farm, stree	t, factory, office b	ouilding, etc.	28f. Location	(Street and Numb	per or Rura	I Route Number, City
Divipital or pital or safte eral Dir filled in	Certification:		d not be rmined (Specify)	Major Road /	Highway			Rt. 235 / St.	, State) Johns Road, H	ollywood,	MD
		29a. Certifier (Check only 1 Certifying P	hysician: To the best of	f my knowledge,	death occun	red at the time, da	ate and place	e, and due to the ca	use(s) and manne	r as stated	cause/s)
To the Hos within 24 h To the Fun	Medical		miner: On the basis of and manner stat	ed.	or investigati				29d. Date sign		
	2	29b. Signature and title of certifie	/			29c. Licens			June 27, 2		.,, , , , , , , , , , , , , , , , ,
	ļ	20 Named and a later of the Contract of the Co	who completed as	of death from 23	32)	0.0.					
(10)		30. Name and address of person Russell Alexander MD				Penn Street,	Baltimore	e, MD 21201			
St	ate	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature		0'	CME				
Regist	trar	JUL U 6	LUIU Kenen	N B.	par						
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State of Maryland / Department of Health and Mental Hygiere Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1230 M **Physician** BARBER BERNICE 06 10 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CROWNSVILLE FAIRFIELD NURSING CENTER ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MARCH | 16,1916 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2 F NEW YORK Yrs. 94 Director 118-10-1203 Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "netural", or Items 23a or 28a-f show treumetic event. The Micdical Examiner must be notified at 1 Yes 2 No Directo **NEW YORK** ONEIDA VERNON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **4 RUTH STREET** UNITED STATES 13476 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be i EDWARD KIRK MARY WITZIGMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an CAROL BARBER BEVIVINO/DAUGHTER 1505 OYSTER COVE DRIVE, GRASONVILLE, MD 21638 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition CHESAPEARE CREMATION 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. STEVENSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) CENTER 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications to it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events nding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown pec Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signe should be þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2□ No 1 ☐ Yes 2 XNo 1 Tyes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) After the funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the Director: 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and Mie o 29c. License number 29d. Date signed (Month, Day, Year) D66753 who completed cause of death (Item 23a) (Type, Print) Capitack No. 7007 Tidewater Colony Dr # 1-4, Annapolis MD 2140) Timoth 32. Registrar's Signature 31. Date filed (Monti State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		State Registrar		1 4)				Ce	rtifica	te of L	Death			Reg.				_
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service	censee	K.	00	ma	ألم	2. Name a	nd Addre	ss of Facili Son	s, P	.A. Se	vern	a Par	rk F	uneral Home	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but Madical Coefficial And Incompleted by Directors and Andrews		only one) 3	Certifying	Nurse I	r: On the bas Practioner:	is of e	xamination best of my	and/or inve	death occi	irred at the	e time, date	ccurred at e and plac	the time, date, and due to	te and pla the caus	ice, and du se(s) and m	e to the o	cause(s) and manner stated stated.	d.
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	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) Name (A Facility Name (If not institution, give stress.)	reet and number)	Bo	Jdwin 4b. City, Town, or	Location of Deat	2. Date of Dea Month June	Day Yea 24 2010 4c. County of D	3135 FIM
) 	Funeral		The Johns Hopkins Hos 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	Baltimore If Under 1 Year Months Days	City If Under 24 Hrs Hours Min		h 9.1	Birthplace (State or Foreign Country)
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0-617	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done of DO NOT use retired ical Perf	during most of we)		16b. Kind of Busine Health	
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Dallimor	t. Page tment tant: If tjury o		4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee		Glen Eder				Livonia, uneral Ho	
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	Examiner	Examiner	Sequentially list conditions, it any, leading Unincipality cause. Enter Underlying Cause (Disease or injury that initiated events	Jun to (or as a	Consequence of):	PRATS.	SION			
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OI VII	ystcian: is certifica director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	t 2 ☐ ER/Outpatier	nt 3 🗆 DOA Oth			dence 6 🗆 Other (S	Specify)
DINISION	of the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director,		27. Manner of Death 1	28a. Date of Injury (Month, Day)	(ear) Injury	M 1	yat k? Yes 2 ∐ No		now injury occurred	
ב ב	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	4 Homicide determined	building, etc.				Cify or Tow	m, State)	r Rural Route Number,
	he Hospi in 24 hou he Funer ipletely fil	edical	(check only 2 Medical Examin		examination and/or in	vestigation, in my o	opinion, death oc		cause(s) and manne date and place, and	due to the cause(s)
	vith COT	Σ	29b. Signature and Title of certifier			RCK RCK	e number	00	June 24	1 2010
4	-10.		30 Name and address of person who co	hV.		, Print)	600	North Wo	olfe St, Baltin	more, MD, 21287
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar'	s Signature	1 11				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registral 22065 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2010 Mariorie Jackson Bradley 28 0755 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Rising Sun Calvert Manor Health Care Center 8. Date of Birth (Month, Day, Yea Anril 11, 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. ^{Year)}1 922 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2**X**□ F 88 219-14-1857 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County 28a-f show dnot rough be restified at 1∭Yes 2 No Cecil Perrvville Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or items and or items 23a U.S.A. 21903 541 Maryland Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 【☐ No Specify: item 27 is marked other than "natural", or other traumatic event, the Weden Expression þ White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lvdia Selik Theodore Jackson မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21904 111 Burlin Road, Port Deposit, Maryland William B. Bradley, Jr. (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/02/10 Port Deposit, Maryland Asbury Cemetery 4 Donation 5 Dother (Specify) ^{22. Name and Address of Facility} Lee A. Patterson & Son Funeral Perryville, Mar<u>yland 2</u>19 21. Signature of Funeral Service Licenses Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burlal-transi Due to (or as a consequence of): attending physician or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Tyes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

3altimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22066 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 06 26 2010 23:40 Teddy Betts Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Howard County General Hospital Funeral Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country)
 TTT Days 1 XM 2 D F Hours 0570571955 55 NY Director 110 48 0471 Usual Residence of Deceden 28a-f shov 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Ellicott City MD Howard 5 10e. Street and Number 10g Citizen of What Country? or items 23a Funeral 21043 United States 4928 Eastwood Place death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian ۵ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ye 1 and 2 should be filed within 72 t of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Betts Olga Preiszer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4928 Eastwood Place Ellicott City, MD 21043 Linda Betts/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 a Department of H Important: If ite ☐ Burial ② Cremation 3 ☐ Removal from State injury or 6-30-2010 Ardent Crematory Hanover, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Acute Abdomen Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed COPD attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No ed by the a Unknown 9 Unknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate has page 2 autopsy performed 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 🔀 No မ 1 Yes 1 Xinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1X Natural 5 Pending within 24 hours after death To the Funeral Director, A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 D0064539 06/27/2010

State Registrar

backer

Srilatha Kanumuru Howard County General Hospital Columbia, MD 21044

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL - 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 06 Month 25^{°°}2010°° Opal Lee Bates 6:15A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick College View Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** GA GA 1 □ M 2 🛣 F 257-18-9801 Director 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Germantown 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 USA 2100 Father Hurley Blvd. #325 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) interior designer interior design Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marshall Ford Morris Jr. Opal Gaulding 19a. Informant's Name/Relationship (Type, Print) Scott Bates (Son) 3202 Hyde Park Ct., Adamstown, MD 21710 20a. Method of Disposition 20b. Place of Disposition (Name of Admetar) nonal 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removal from State tion 5 ☐ Other (Specify) 1 XPúria 7/28/2010 Arlington, VA Dona Cemetery 2 Name and Address of Facility Donald B. Thompson Funeral Home nature there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest report failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enysician/ Dement disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impory Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last use as the burialthe attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year detached 1 ☐ Yes ∠∠ g ☐ Unknown funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2-No 3 Probably 4 Unknown 1 Tyes Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 🗌 Yes 2. No 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗆 Yes 2 🗆 No 1 Natural Accident Investigation completed filled in by the Suicide 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Sig ature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Dr. Fredenick MD 2/702

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

29

2010

32. Registrar's Signature

		ŀ	For State Registrar		State of I	Marylan		artment of I tificate of I					2010	22068
	Physicia	ın/	1. Decedent's Name (First	t, Middle, Las	t)						2. Date of De Month	ath		3. Time of Death
,	Medic Examir	cal	Russell Lee 4a. Facility Name (if not in:			r)		4b. City, Town, o	r I ocation	of Death	June 2		2010 Year	1:00 A ^M
- 1	LAGIIII	ICI	17755 Annap	olis R	ock Road			Woodbine		, or Bouilt			Howard	
	Funeral Director		5. Social Security Number 228–19–0984	6. Se		Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da Jan. 2	th y, Year)	9. Bir Co 1974 Vir	thplace (State or Foreign untry) g ini a
	show at	ě	Usual Residence of Deced 10a. State 10b.	dent County		10c. Cit	y, Town or Loc	ation						10d. Inside City Limits
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	th the	alDi	10e. Street and Number					10f. Zip Code					Citizen of What Co	ountry?
	ath wil	Funeral Director	17755 Annapo	lis Ro	ck Road 12. Was Deceder	nt Ever in U.S	S 13 V	21797 Vas Decedent of H	lisnanic O	rigin? (Sne		USA	14. Race - Ame	rican Indian
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 X Never Married 2 3 Widowed 4 D		Armed Forces 1 Yes 2 If Yes, Give Year or Dates	S? XX No	l I	Yes, specify Cuba	an, Mexic	an, Puerto P	Rican, etc.)		Black, White	e, etc.
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re,	1 and of Hea item		20a. Method of Disposition	n		20b. F	lace of Dispo	sition (Name of patory or other place			ate Road,	_	Location - City or	
Baltimore,	Page ment tant; If		1 ABurial 2 Cre	Other (Specify	2		ınt Oli	vet Ceme	tery					Maryland
Balt	permit Depart Import any inj		21. Sign ture of Funeral	u. Lice	Dersu			Name and Addre						Funeral Home 20872
П			23a. Part 1 Frier the dise show, or leart failur	ease, or comp re. List only or	olications that caus ne cause on each	sed the deatline.	h. Do not ente	r the mode of dyin	g, such a	s cardiac o	respiratory ar	rest,		Approximate Interval Between
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E	sician; The certificate l rector, page	Be C	25. Was case referred to mexaminer?		4 2 1					ath (Check	1 □ Yes only one)	27/1	No 1 ∐ Yes	
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Divisio	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate:		Could not be determined	28e. Place of I	njury - At ho etc. (Specify,		et, factory, office		2	28f. Location (S City or Tow			ral Route Number,
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	vithii To th	-	29b. Signature and title of	certifier				29c. License	number				ate signed (Month	
			> / Kangn	und NV	mli m	ρ		1 7	2471	683		6	27/10	
	5		30. Name and address of p	person who collins 2	ompleted cause of	death (Item	23a) (Type, Pi	int) Bulling	K-	MD :	21209			
	Stat Registra	e	30. Name and address of purify monal Mills 31. Sale filed (Month, Day,	Year) UN 29	32. Regis	trar's Signat	ure A.	parked						·

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 25 per phys. 6906 8/10/10 dk
State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. N 2010 22069 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0410 WAYNE ALLEN BROBST 2010 JUNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Easton Talbot Memorial 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Sex 1 M M 2 □ F Year) 952 Months Days Hours JULY 30, MARYLAND Director 216-56-2366 57 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MARYLAND QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2431 RUTHSBURG ROAD 21617 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10 College (1-4 or 5+) CARPENTER CONSTRUCTION Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ SAMUEL ROBERT BROBST VERDA LUCETTA ERVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARLENE ERVIN/SISTER 2431 RUTHSBURG ROAD, CENTREVILLE, MARYLAND 21617 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of CHESAPEARE CREMATION JUNE CENTER 2010 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME P.A.
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Collapse Physician/ Cardro vescular disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 1 ☐ Yes 2 L 9 ☐ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure Renal 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death,

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 X Yes 2 🗆 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RMohan D0069567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and address of person who completed cause of death (Item 23a) (Type, Print) (avi Mohan M.D 219 5: Wishington St. Memorial Hospital, Easton, M.D. 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2 Mayne

State of Maryland / Department of Health and Mental Hygiene For State Registrar 22070 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Jüne 0914 A. M Gwendolyn Bernice Bridges Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Suitland 5000 Lydianna Lane # 324 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 1 □ M 2 🕱 F Hours Min 547-72-3792 76 Yrs D.C 01/16/1934 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10h. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No Md. Prince George's Suitland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 20746 U.S.A. 5000 Lydianna Lane # 324 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African-1 Yes 2 X No Specify: is marked other than "natural", aumatic event, the Medical Exa 3 Widowed 4 Divorced Completed American 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Education 4 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin Franklin Bridges Sallie Sizemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Massachusetts Ave., S.E., Washington, D.C. 20019 Gynetha B. Shackelford/Sister 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 07/06/10 Suitland, Maryland Lincoln Mem. Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Henry S. Washington & Sons Co., Inc.
4925 N.H. Burroughs Ave., N.E., Wash., D.C. 20019 rale 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Lymphoma Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Pregnant at time of death 5 Other (specify) ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 욘 4 Nursing Home 5 Residence 6 Other (Specify) this Director: After this in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 💹 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined ☐ Homicide de Funeral Dire Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number June 30,2010 D32864 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 20037 Ari D. Fishman M.D. 2141 K St., N.W. # 707 Washington, D.C. State JUL 0 **1 2010** Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		State of Maryland					lental Hy	giene			
		State Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate	of Dear	th	2. Date of Dea		010	3. Time of Death	
Physicia Medic		Curtis Joseph Callaway	Mo			June 23	Day	10 Year			
Examin	_	4a. Facility Name (if not institution, give street and number) Mercy Medical Center			4b. City, Town, or Location of Death Baltimore			4c. County of Death			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1		nder 24 Hrs.	8. Date of Birt	h , Year	C	irthplace (State or Foreign ountry)	
Director		222-28-8738 1 K M 2 L F 64	Yrs.				Dec. 8	1945	De De	Taware	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Diopartment of Health and Mental Hygiene. Diopartment of Health and Mental Hygiene. Important: I firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Crofton 1 Mayes 2 □ No									
	Dire	10e. Street and Number		10f. Zip Code 10g.				Citizen of What Country?			
	Funeral Director	1857 Marlow Place			21114 Was Decedent of Hispanic Origin? (Specify Yes or N				U. S. A.		
ter dea or iter	by Fu	11. Marital Status 1 Never Married 2 M Married 12. Was Decedent Ever in U.S. Armed Forces? 1 No Yes 2 No	If	Yes, specif	Cuban, Me	xican, Puerto I	Rican, etc.)		Black, Whi		
ours at atural", cal Exa	eted	3 Wildowed 4 Divorced If Yes, Give Year or Dates. 1967-69 1 Yes 2 X No Specify: Specify: White									
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d 2 shou alth and 1 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) Yvonne Callaway/Wife	19b. Mailin 1857	g Address (Marlo	Street and No W Plac	umber or Rura ce, Cro	ofton,	; City or To Mary 1	and 21	ip Code) 1114	
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mit. Pa partmer portant / injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	22		Address of F	acility ROL	/2010 pert E.	Evan	s Fune	le, Maryland eral Home	
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Medical Examiner		disease or condition resulting in death) Due to (or as a consequence of):									
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and -transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last									
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Within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit	Physician/Medi	in the past 12 months?	1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year		
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ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, stre			M 1 Yes 2 No				Street and Number or Rural Route Number,		
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in 24 hours in 24	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
Veith Com		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C0002607 29c. License number 29d. Date signed (Month, Day, Year)									
1011		30. Name and address of person who completed cause of death (Item 2	3a) (Type, P		JU26U7	<u> </u>	()	00	231	auto a Belt	
- Idtl Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signatur		rer	CY/	Ledic	al Cer	iter	501	+ 1cul 11. 212	
Registra	ar	JUN 2 8 2010	1. 6	and							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Arnie Levering Calvert М 4:55 June a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Cecil Elkton Union Hospital of Cecil 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** ^{Year)}19<u>65</u> Days Sept. Day 212-02-9307 1**火**□ M 2 □ F Months Hours Min Maryland 44 Director Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Cecil North East 1 Tes 2 No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21901 1952 Turkey Point Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married à けい、 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Station Services Elementary/Seconday (0-12) College (1-4 or 5+) Twelve Years Amtrak Railroad Train Announcer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ina Leona Rutherford Wayne Jerry Calvert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1952 Turkey Point Road, North East, MD 21901 (brother) Henry Calvert 20a. Method of Disposition 20c. Location - City or Town, State West Chester. 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Co..Inc: 07/01/10 Pennsylvania 21. Signature of Funeral Service Licer Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 50 Physician 0 disease or condition resulting in death) Q Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician The law requires that the death certificate be Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery ☐ Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown detached g Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 XInpatient 2 - ER/Outpatient 3 - DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 Natural work? 5 Pending 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 5 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dimonson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:05[™] June 28, 2010 Shirley Ellen Clark /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Egle Nursing and Rehab Center Lonaconing If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Davs Hours 1 □ M 2 🕱 F Maryland Director 215-76-6256 March 18, 1936 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Expressment out that 1 □Yes 2 □ No Director Lonaconing Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 57 Jackson Street 21539 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify þ 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked Never Worked 0 n 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Ellen Hacker Milton Alvin Clark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. Ronald Cecil- Brother 1811 Reese Manor Drive, Finksburg, Maryland, 21048 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 30. ↑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lonaconing, Maryland Oakhill Cemetery 2010 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Eichhorn-McKenzie Funeral Home P.A Lonaconing, MD 21539 8 East Main Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** month incephalopotr disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of): burial attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 □ Yes 2 🗷 No 1 ∐Yes 2 No 9 ☐ Unknown Day 4 Pregnant at time of death 5 ☐ Other (specify) the signed by Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 XNo 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year, 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No after death 3 🗀 Suicide 6 ☐ Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed caus of death (Item 23a) (Type, Print)

State Registrar

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31. Date filed (Month, Day, Year)

JUL - 1

P.O. Box 68760.

11600 Brotford Road NE, Cumberland, Mary Land, 21502

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Trease Type of Frint in plack incellible ink. Ensure All Copies Are Legible.

				partment of Health and N ertificate of Death		2010	22074	
			1. Decedant's Name (First, Middlu, Last)		2. Date of Death		3. Time of Death	
	Physicia /Medic		Willard Alfred Carr		June 28	28 2010 9:00		
	Examin		4a. Facility Name (If not institution, give street and number)	45, City, Town, or Location of Death	4	4c. County of Death		
4			115 Crellin Street	Oakland		Garrett		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Mrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	9, Birthp	ace (State or Foreign	
	Director		218-38-0147 124 M 24 F 67 YCS. Usual Residence of Decembers	STREET TO STREET	Apr 5, 19	43 Cre	llin, MD	
	P 3		10a. State 10b. County 10c. City, Town or	Location		11	Od. Inside City Limits	
	Lish	ğ	MD Garrett Oakland			1 🗀 Yos 2 💬		
	ith the Maryian or 28a-f show e-rollfiedel	Director	MD Garrett Oakland	10f. Zip Code	10g. (. Citizen of What Country?		
	death with the Karyland ms 29a or 28a4 show poust be collised at	0	ll5 Crellin St	21550		USA		
	deali	Funeral	10 Mar December Completition	Wos Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerro	eolly Yes or No-	14. Ruce - Americ	an Indian,	
0	or the	2	1 □ Never Married 2 □ Married 1 20 Yes 2 □ No; G /2 2 = 1	ti Yes, specify Cuban, Mexican, Puend t □Yes 2 🐼 No Specify:	Rican, etc.)	Black, White, a	ote.	
2	72 hours mallural", died Ene	d by	3 ☐ Widowed 4 ☑ Divorced If Yaa, Give Year or Dates: /965	TLITES ZINING Specify:		Specity: While	te	
7	42 BE	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	zedont's Usual Occupation ve land of work dene during most of work . DO NOT use retired)	ing 16b.	Kind of Business/Inc	Sustry	
2	within lene. then	dw	Elamentary/Secondary (0-12) Collage (1-4or 5+)			· -		
7	he fied within 72 hours after death with the Maryla Mid Hyghen Andurel", or teams 23s or 23s 4 shot event, it e Medical Exemper must be notified at		12 Mac 17. Futhor's Name (First, Middle, Last)	hinist	e (First, Middle, Mala	anufactur:	ing	
_	nouls be filed i Mordel Hyp naukas other netic event, I	Be	Leonard Carr	Ida Me:		en surmine)		
7	thould be filed nd Menla! Hygi marked other unatic event, it	ဥ		Illing Address (Street and Number or Rus		v or Town State 710	Cortui	
n n	the state			Box 94 Mill Hall.	Or other first	y 0. 70 m., 0.210, 2.p		
Ď	F 1 g F Hear Item other		20u. Method of Disposition 20b. Place of Dis	, , , , , , , , , , , , , , , , , , , ,		Location - City or To	wn, State	
2	Page Next of Int: If			cland Crematory 7-3	3-2010 Cur	mberland,	MD	
	permit. Pages 1 and 2 should to Department of Neath and Monti Important: If tem 27 is manifed any Injury or other traumatic of pance.		21. Signatura of Funaral Service Licenses	22. Name and Address of Facility David A. Burdock	1	Jome P A		
a	12558		Hard H. Dudock	21 N. Second St.	, Oakland	, MD 2155	0	
			23a. Part 1/Enter the disease, or compileations that caused the death. Do not a shock, or heart fallure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Batween Onset and Death	
F	hysician		Immediate Cause (Final disease or condition SND STACE)	(09D)			Onset and Death	
,	/Medical Examiner		resulting in death) Due to (or as a consequence of):				3	
ď	LXdIIIIIei	<u>.</u>	Sequentially list conditions, b.					
	de de	듣	Sequentially list conditions, if any, legisling to immediate cause. Enter Underlying Cause (Disease or injury that intillated events resulting in death) Lest Due to (or as a consequence of): C. Due to (or as a consequence of):					
_	exec. n and altre	Examine	that inklated events c. Due to (or as a consequence of):					
00/00	te be							
8	eath certificate be executed attending physician and for use as the bunal-transit	an/Medical						
XOD	~ = 3	20	IF FEMALE: 23c. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	Estopic pregnancy		23d. Date of delive		
	# @ B	Bicl	1 Yes 2 No	5 Other (specify)		Month	Day Year	
Ĺ	ires that the deatt signed by the atte is be detacked for	Physici	⊕ Unknown Part II. Other significant conditions contributing to death but not resulting in the	Market and the second s	Ode Distance	o use contribute to t	and a state of the	
ŝ	signe Signe d be d	á	Fig. 11. Outline by interest Contributing to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes		ably 4 Unknown	
50.00	w requir been s should	etec						
ב ב	GE 47 CH	Completed		,",", , , , , , , , , , , , , , , , , ,	24s. Was an autopsy performed	prior to co	psy findings available impletion of cause of	
B	Physician: The l this certificate he al director, page (25. Was case referred to medical		1 🗆 Yes 20🗆	No 1 ☐ Yos	2 🗆 No	
5	Physician: ribis certific ral director, p	To Be	examine?? 1 Yaa 2 No Hospital: 1 Inpetiont 2 ER/Outpat	Other	th <i>(Check only one)</i> ome 5 🖾 Residence	6 □Other (Speed	64)	
5	다 원 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등	ı.	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how in		"	
	Party St. Party	atio	2 Accident Investigation	M 1 Yes 2 No				
2	in by it	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, building, etc. (Specify)	28f. Location (Street City or Town, St	l and Number or Rure tete)	al Route Number.		
5	pitel burs filled		29a. Certifier Certifying Physician: To the best of my knowledge, de	SHI AAAAAAA AAAAA		-/->-		
	To the Nospital or Attanding P within 24 hours efter death. To the Funeral Director: After t completely filled in by the funeral	Medical	29a. Certifier (Check enly one) 12 Certifying Physician: To the best of my knowledga, de cone) 2 Medical Examiner: On the best of examination and/or and manner stated.	Investigation, in my opinion, death occur	red at the time, dete	and place, and due t	o the cause(s)	
_ 1		Z.	28b. Signature and title of certiflar	29c. License number	29d.	Data signed (Month,	Day, Year)	
r	4	7	a land stand Me	- HZ6154		76011	0	
		. 4	30. Name and address of person who completed cause of douth (from 29a) (Typ	Print LG CO	I Area	DI D	M. Mo	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	MAN O. 1 - NO	4 ~ 10/82		1100	
	Registra	er	JUL - 2 2010 James S.	pare			LVIT	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2, per phy, g915 5-24-11 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First Middle | ast) 2. Date of Death 22 3. Time of Death Physician/ TYNY. 2 Day 2010^{ar} 5:17 A M CRAYTON ANNIE L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY SUBURBAN HOSPITAL **BETHESDA** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🛣 F Days Hours Min. (Month, Day, Ye VIRGINIA **Director** 225-40-6915 1933 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 639 KENSINGTON PLACE N.E. 20011 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT COMPUTER OPERATOR 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARY FARLEY LUTHER WORSHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other the once. KENSINGTON PLACE N.E. WASHINGTON, DC 20011 639 GLORIA THOMAS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Gremation 3 Removal from State 4 Donation 5 Other (Specify) INCOLN CEMETERY 6/28/2010 BRENTWOOD, MARYLAND Ignature of Funeral S / ce Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final "Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ After this certificate has been signed by the atte funeral director, page 2 should be detached for in the past 12 months? Pregnant at time of death 1 Yes 2 7 2x No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 1 ☐ Yes 2 🛣 No 2X No the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? X Natural 5 Pending iniury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 20 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar

DHMH 17 Rev 7/2009

State

EDWARD

31. Date filed (M

BROWN M.D.

nth, Day, Year,

Registrar's Sign

8600 OLD GEORGETOWN ROAD BETHESDA, MARYLAND 20814

22076 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Physician/ 2010 1:12 A M Florence L. Duke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Ocean City 152 Pinetree Rd. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 12/05/ If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday **Funeral** Days Min. 1 🗆 M 2 🔀 F Hours 84 MD 216-22-3261 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampiring or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 V No City MD Worcester Ocean 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 152 Pinetree Rd. 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced white Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Post Engineering Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ruth Wheeler Charles Lattuca, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 152 Pinetree Rd., Ocean City, MD 21842 Friend Orvin D. Heimsness 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State MD Vet Crownsville 6/24/2010 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Metastatic Immediate Cause (Final arel Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a number tence of: the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes No Month Year Dav Pregnant at time of death 5 Other (specify) 1 Yes been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I perform 2 No 1 Tyes certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Tyes 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Fractioner Tot is best of my knowledge, death oncum at the time, date and staps, and due to within 2 To the UITY UTTO 29d. Date signed (Month, Day, Year) 29c. License number -⊖ 6/23/10 pleted cause of death (Item 23a) (Type, Print) Name and address of person who c

Registrar

Gel

JUN 2

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PO BOX1733

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE 20 2010 ay 4:35 P M FRANK DAVIS LEE JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CLINTON NURSING HOME CLINTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min Month, JUNE NORTH CAROLINA Director 579-48-6919 75 Ĩ934 Usual Residence of Decedent 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits the Maryland Director 28a-f MD PRINCE GEORGES 1 X Yes 2 □ No FORT WASHINGTON 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the M. cical Examiner must be I Funeral with 12108 CLEAR CREEK DRIVE USA 20744 permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE DRYWALL FINISHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ DAVIS JR. FRANK LEE EUNICE GWYNN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROMONA JOHNSON/ SISTER 12108 CLEAR CREEK DR., FT. WASHINGTON, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY JULY 1,2010 CLINTON, MARYLAND 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. caen disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Erner Underlying Cause (Disease or iinjury Due to (or as a consequence of) ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 2 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4XXNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Datural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D0025640 JUNE 24, 2010

State Registrar

DHMH 17 Rev 7/2009

KHOSROW DAVACHI M.D. 7801 OLD BRANCH AVENUE #409 CLINTON, MARYLAND 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 0 1 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Richard Dinkins June 24 10:40A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Birthplace (State or Foreign Country)
 SC 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 XM 2 7 F 250-78-5287 Director 63 30.1947 May Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Oxon Hill MD PG 10e. Street and Number 10g. Citizen of What Country? Funeral 1901 Knoll Drive 20745 United States death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married Yes 2 No Yes, Give ģ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 lith and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Construction Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Dinkins Susanna Loney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 12 Earnshaw Drive andywine, Md. 20613 Susie Grant/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State 6/29/10 4 Donation 5 Other (Specify) Washington Nat. Cemetery Sujtland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner lower Sequentially list conditions, frany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of that the death certificate be executed END and Due to (or as a consequence of) resulting in death) Last burialsician Physician/Medical Box 68760 phys: attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Yes 2 No a Unknown 9 Unknown P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been signatures Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate Yes 2 No Yes 2 4 No director, 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

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31. Date filed (Month, Day, Yea

JUL 0 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 25640

BRANCH AUX. CCINTON.

		Plea	ase Type or Pri						-		egible.	
	-	For State Registrar	State of IV	laryland / D	repartmer Certificat			and iv	ientai Hy	Reg. No.	010	22079
Physicia	n/	1. Decedent's Name (First, Middle		Friedmo	0				2. Date of De Month	eath Day	Year	3. Time of Death
Medic Examin	al	Elliott 4a. Facility Name (if not institution		ricomo		, Town, or	Location c	of Death	<u> </u>	2.5 4c. Co	unty of Dear	4: 25 A M
		University of M 5. Social Security Number				t Year	ح^د If Under:	City			Q Dis	4h-laa (C4+4
Funeral Director		212-34-2890	6. Sex 1 X M 2 □ F	ge (In yrs. last birth	/rs. Months		Hours	Min.	8. Date of Bir JULY 7		MARY	thplace (State or Foreign untry) (LAND
show d at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
ie Mary ir 28a-f notifie	Director	MARYLAND QUEEN 10e. Street and Number	ANNE'S	СНЕ	STER	p Code			ı	10a Citizer	of What Co	1 Yes 2 X No
within 72 hours after death with the Maryland giene. giene than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	Funeral	224 CROSS CREEK	COURT			216	19			_	D STAT	
or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 又 Mar	12. Was Decedent Armed Forces? ried 1 😿 Yes 2 🗆		If Yes, spe	cify Cuba	n, Mexican	i, Puerto I	cify Yes or No- Rican, etc.)	14.	Race - Ame Black, Whit	erican Indian, e, etc.
ours afte tural", al Exar	ted k	3 Widowed 4 Divorced	If Ye s, Give Year or Dates.		1 🗆 Yes						ecify: WH]	
n 72 hc s. ian "na Medic	Completed		nt's Education est grade completed) College (1-4 or		Decedent's Usu (Give kind of wo life. DO NOT us	rk done d		t of worki	ng		of Business	
ed withi Hygiene ther th	Be Co	17. Father's Name (First, Middle, I	5+		RESIDEN	T	18 Mothe	er's Name	e (First, Middle,		EN FOO	OD
d be file Mental I arked c	인	PHILIP FRIEDMAN	,						YBUSH		14110)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations ELAINE MARKS FI			Mailing Addres CROSS							
ge 1 and t of Hea If item or othe		20a. Method of Disposition 1X Burial 2 Cremation		20b. Place of cemeter)	Disposition (Na , crematory or	other plac	-/	UNE [-	Town, State
mit. Pag bartmen bortant: ' injury		4 Donation 5 Other (5		OXFORD	CEMETE 22. Name a			2010			-	HOME P.A.
any me			+R		106 SH	AMRO	CK RO	AD,	CHESTE	R, MAR	YLAND	21619
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Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a consequence of		<u> </u>	Noop				_	Deys
	ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of	f):						_	
and transit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequence of	n:	-						
£ 5.00	_	resulting in death) cast	L d									
ertificat ding ph	/Mec	IF FEMALE:	23c. If yes, outcome	e of pregnancy						224	Doto of do	Sliveny
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth	2 Fetal death at time of death	3 Ectopic 5 Other (s		у			230	. Date of de Month	Day Year
that the ned by the detach		Part II. Other significant condition	ons contributing to death	but not resulting in	the underlying	cause giv	en in Part	1.	23e. Did	tobacco use	contribute to	o the cause of death?
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sian: Th ertificat ctor, pa	Be Co	25. Was case referred to medical examiner?	III				ace of Dea	th (Check		2 X No	I L. Ye	s 2 X No
r this co	မ	1 Yes 2 No 27. Manner of Death	28a. Date of inj		me of	28c. Injur	4 ∐ Νι yat		me 5 Res			cify)
tending eath. or: Afte the fun	Certificate:	1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could	gation not be		jury M		Yes 2 🗆			-		
al or Att s after d I Direct d in by		4 Homicide determ	ained 28e. Place of In	jury - At home, fan tc. (S <i>pecify</i>)	m, street, facto	ry, office			28f. Location (City or To		umber or Ru	ıral Route Number,
Hospita 24 hours Funera sted fille	Medical	(Check 2 Medical E		examination and/or	investigation, in	my opinio	on, death od	ccurred at	the time, date	and place, ar	d due to the	cause(s) and manner stated
To the within to the To the Comple	Ž	only one) 3 L Certifying 29b. Signature and title of certifie	y Nurse Practioner: To the	e best of my knowle			e number	e and plac	e, and due to t			th, Day, Year)
14.			M.D			P2	443	2		C	25/	2910
Solus		30. Name and address of person Norlin Beaty	willo completed cause of a			12-7	B.	Mima	er, Mi	212	01	
Stat Registra		31. Date filed (Month, Day, Year) JUN 29		rar's Signature	,							
		3011 20	CUIU /COTICAL	→	Buch	/						

State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last)
Richard E. Fran 2. Date of Death Francis ^{Day}201<u>0</u> Physician/ A M June 26 4:08 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1421 Landmark Terrace Crownsville Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Date of Bill...
(Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Hours M 2 🗆 F Director 107-28-2728 Sept. Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Crownsville 1 🗆 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1421 Landmark Terrace United States 21032 12. Was Decedent Ever in U.S. Armed Forces?

1 2 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: al Hygiene.
ad other than "natural"
ad other than "natural"
and other than "natural" Completed 3 Widowed 4 Divorced White Year or Dates. 1960–66 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Southern Pacific Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supply Co., Inc. President Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed thand Mental H is marked of Eugene Francis Marian Hostrander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau Dolores J. Francis / Wife 1421 Landmark Terrace, Crownsville, MD 21032 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Mem'l Grdns 06/30/2010 Davidsonville, MD 22. Name and Address of Facility Beall Funeral Home Signature of Funeral Service Licensee AS 6512 NW Crain Hwy., Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ -Una disease or condition resulting in death) Cance-Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Die to (or se a noneéquence of) -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): the burial as been signed by the attending physician 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy the funeral director, page After this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2. No Hospital Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 \(\sum_{\text{Nursing Home}} \) Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a title of certif 29d. Date signed (Month, Day, Year) 29c. License number 6/28/10 on who completed cause of death (Item 23a) (Type, Print) 400 300 DUNABULY 31. Date filed (Month, Day, Year)
JUN 2 9 2010

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22081 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vear 19:25 PM Anna M. Fleming Ju<u>ne</u> 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 2 9. Birthplace (State or Foreign Country) Maryland Funeral 1 🗆 M 2 🖾 F Months Days Hours Min 89 Yrs Director 216-32-3508 Usual Residence of Decedent 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2905 Center Street 21037 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 'n, þ 1 Never Married 2 Married 1 Yes 2 X No 1 ☐ Yes 2 X No Specify. White "natural" 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Dealer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Charles Durm Emma Mildred Hildebrandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny L. Nichols / Granddaughter 2905 Center Street, Edgewater, Maryland 1 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 0 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 Hillcrest Cemetery 6-29-2010 Annapolis, Maryland 21. Signatur Fune Sevice In 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd Edgewater, MD 21037 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cau Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year page 2 should be detached Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has Is autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Vital Be 26. Place of Death (Check only one) Hospital 2 No Other: Certificate: To 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 \square No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗓 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Martical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

German, Nuran Practican of To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner as stated. (Check only on e of certifier 29b. Signature ar

DHMH 17 Rev 7/2009

State

Registrar

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JUN 2 8 2010

			1 - For State Registrar	of Mary			it of Heal <i>e of Dea</i>		lental Hyg	giene Reg. No. 2010	22082	
Г	Physicia		Decedent's Name (First, Middle, Last) Mar	y Colleen	Fazenbak	er			2. Date of Dea Month	July 01, 2010 3. Time of Death 8:30 M		
many.	/Medic Examin		4a. Facility Name (If not institution, give street and		10.39	4b. City,	Town, or Local			4c. County of Death		
	Francis		5. Social Security Number 6. Sex		a S.W.	ay) If Unde		nder 24 Hrs.	coning 8. Date of Birth		Allegany thplace (State or Foreign	
ь	Funeral Director		220-32-4315 1□ M 2▼		74 Yrs	Months	Days Ho	urs Min.	(Month, Day May	11, 1936	thplace (State or Foreign buntry) Maryland	
	w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or	Location					10d. Inside City Limits	
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	or 28a	Director	10e. Street and Number			10f. Zi	Code			ountry?		
	s 23a	ral I	16600 Bluebaugh			- W - B		21539	i6 . Wa a av Na		USA	
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lan.		To Be	Charles Cl	ary Olive Ricke	r							
Maryland 21215-0036	har har risu		19a. Informant's Name/Relationship (Type. Print) Mark Fazenbaker -	Son			er, City or Town, State, naconing, Mary					
altimore,	S to E I		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fr			crematory or	other place)	1	Date	Town, State		
Ħ	Pa in:		4 ☐ Donation 5 ☐ Other (Specify)		Cu		Crematory	1	uly 03, 2010		and, Maryland	
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I Records,	The law requires that the cate has been signed by the page 2 should be detache	Completed							24a. Was autop perfo 1 □Yes	osy prior to rmed? death?	autopsy findings available ocompletion of cause of successions 2 No	
Vital	Physician: T r this certificat ral director, pa	Be (25. Was case referred to medical examiner? Hospital:				Othor	Place of Deat	th (Check only o	one)		
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	To the within 2 To the complet	Me	29b. Signature and title of certifier	2		2	9c. License nun	mber		29d. Date signed (Mor	nth, Day, Year)	
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	Sta Registi	ite	31. Date filed (Month, Day, Par)	32. Registrar's	Signature	A. A	all I	NAC LA	nd, Mo	a grand, a	XXIX X	

DHMH 17 Rev 1/2001

10-04658
Nicholas Ada

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 22083

State of Maryland / Department of Health and Mental Hygiene

cholas Adam	Grig	1- For State	aryland / Depa <i>Ce</i>	artment of rtificate of			Menta	ıl Hyg			JIL) 22003
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		" " "			-		Date of Deat	n		3. Time of Death
edical Exami		Nicholas Adam Grigs 4a Facility Name (if not institution, give street		La	o City T		ocation of D		Month June 20, 2	010	ear	1705 hrs
-		3997 Shamrock Court	and number)	41		epublic		Jean		4c. Count Calver		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 2	24Hrs. 8 Min.	3. Date of Birt	h(MM/DD/YY	Foreig	thplace (State or
Director		212-23-0661 1XM 2	F	27 Yrs.	IVIOITITIS	Days	nours	tVIIII.	June 2	20, 198	33 ^{Co}	o ^{untry)} Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Locatio	on		<u> </u>					10d. Inside City Limits
and show nce.	or	Maryland St. Mary's	Le	xington	Park	:						1 Yes 2 No
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death with the Maryland or items 23a or 28a-f show any must be notified at once,	Funeral		med Forces? Yes 2 X No				Mexican, Pu				nite, etc.	roan moian, black,
	by F	3 Widowed 4 Divorced If Yes, Cor Date	Sive Year s:		_	X No				Specify		hite
2 hours		15. Decedent's Education (Specify only higher Elementary/Secondary (0-12) Co	est grade completed)	16a. Decedent during mo			n (Give kind O NOT use			16b. Kind of	Business/	Industry
036 rithin 7 ene rr than fedica	Completed		4	Contrac	t Sp	ecia	list			Defens	se Co	ntractor
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212 ald be Menta marke	To Be	19a. Informant's Name/Relationship (Type, Pri		19b. Mailing	Address				B. DeMa		own. State	e, Zip Code)
Z sho 2 sho 27 is	_	Martin Franklin Gr										20676
re, l s l and f Heal If item er tra		20a. Method of Disposition 1 Burial 2 X Cremation 3 Rem		Place of Disposit crematory or other		e of ceme	tery,	D	ate	20c. Location	n - City or	Town, State
imore Pages I ment of F tant: If i		4 Donation 5 Other Specify:										, Virginia
Balt permit. Departi Import injury		21. Signature of Funeral Service Licensee Kyle S. Simons MO1	206	22. Na	me and A	Address o	f Facility	Raus	sch Fur	neral H	lome,	P.A. c, MD 20676
Physician		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.										Approximate Interval Between Onset and
'Medical taminer		Immediate Cause (Final disease a Blunt	Force Head Trau									Death
		Sequentially list conditions, b.	or as a consequence of	of):								
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60, cate be ev	Med		If yes, outcome of preg	gnancy						23d. Date	of deliver	у
ox 6876 eath certificate attending phy for use as the b	cian/M	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of de	eath	al death er (Speci		Ectopic pr	regnancy	1	Month		Day Year
Box e death the atte	Physici	1 Yes 2 No 9 Unknown 9	Unknown									
Division of Vital Records, P.O. Box 68760, To the Hospital or detailing Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi	ğ	Part II. Other significant conditions contrib	uting to death but not r	resulting in the ur	derlying	cause giv	en in Part I	l.			_	the cause of death? bably 4 Unknown
ords, v requir s heen s	Completed								24a. Was a			utopsy findings available completion of cause of
Reco The law cate has	mo								perform		death? 1 ✓ Y	es 2 No
tal Rectism: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital:				In	f Death (Ch					
of Vi ng Physi After this nneral di	ပ္	1 ✓ Yes 2 No 27. Manner of Death 28a	1 Inpatient 2 a. Date of Injury	ER/Outpatient 28b. Time of In		Bc. Injury		lursing F		Residence 6		er: Scene
ion (tending eath tor: A)	ation	1 Natural 5 Pending Investigation	(Month Day Year) In 20, 2010	1657 hrs		1 Ye	s 2 🗸 No	。 Dr	iver auto f	ixed objec	t collisi	on
Jivis al or At a after d I Direct ed in by	Certification:	3 Suicide 6 Could not be	e. Place of Injury - At h		, factory,	office bui	lding, etc.	28	or Town, St	treet and Nur tate) k Court, Po	nber or R	ural Route Number, City
Hospitz 4 houri Funera ely fille	S	4 Homicide 29a Certifier 1 Certifying Physician: To	pecify) Local Stre		ed at the t	time, date	and place					
To the I within 2 To the I	edical	one) 2 Medical Examiner: On the										
	ž	29b. Signature and title of certifier				C.C.M				29d. Date signal June 21,		onth, Day, Year)
		30 Name and address of person who complete	od cause of death (lies	n 23a)		U.U.IVI				Julie 21,	2010	
			ant Medical Exar		Penn S	treet, B	altimore	e, MD 2	21201			
St Regis	tate	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure	6 0					 -		

Green-McDoNALD , MARTHA Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	se Type or F								•	
	_	For State	State of	Maryland	•		of Health of Death		Mental Hy		2010	22084
		Registrar 1. Decedent's Name (First, Middle,	Last)		06/	uncate	Dealii		2. Date of De	Reg. N eath	2010	3. Time of Death
Physicia Medic		Martha A.	Green-	McDona	ald				June	28	2010	78454 M
Examin		4a. Facility Name (if not institution,				4b. City, To	vn, or Location	n of Death	1	4	c. County of Deal	h
A		Doctors Comm 5. Social Security Number		spital . Age (In yrs. las		La If Under 1	nham	er 24 Hrs.	8. Date of Bi			Georges
Funeral Director		038-38-0883	1 M 2 K F	. Age (III yrs. Ias			ays Hours		(Month, D	ay, Year)	. 1954	thplace (State or Foreign untry) VA
d t		Usual Residence of Decedent 10a. State 10b. County		100 City	Town or Loc	action	-		11020			10-1 1-2-1-2-2-1-1-1-1-1-1-1-1-1-1-1-1-1-1
arylan a-f sh fied a	Director	DC Tob. County										10d. Inside City Limits 1 X Yes 2 □ No
the M or 28 e noti	ä	10e. Street and Number			wasni	ngton 10f. Zip Co				10g. C	Citizen of What Co	
s 23a	Funeral	4636 A St., S	SE				2001	9		Ur	nited S	tates
s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at		11. Marital Status	12. Was Decede Armed Force	es?		Vas Decedent f Yes, specify	of Hispanic C Cuban, Mexic	origin? (Span, Puert	pecify Yes or No o Rican, etc.)	-	14. Race ~ Ame Black, White	
s after al", o Exami	d by	1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1		1	☐ Yes 2X	No Specif	fy:			Specify Bla	ck
hours hatur dical	olete		it's Education st grade completed)		16a. Deced	lent's Usual C	ccupation one during mo	act of war	kina	16b.	Kind of Business	
hin 72 ne. than ' te Me	Completed	Elementary/Seconday (0-12)	College (1-4	or 5+)	life. Do	O NOT use re	ired)		KIIIY			
be filed within 72 hours after death with the Maryland ontal Hyglene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	a	17. Father's Name (First, Middle, L	1 4		EEC	Spec	ialis 18 Mot		ne (First, Middle		overnme	nt
permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exanones.	욘	Luma Green	,					ver]		_		
2 should th and M 27 is mar traumati		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (S	reet and Num	ber or Ru	ral Route Numb	er, City c	or Town, State, Zij	Code)
and 2: Health tem 27		LeRoy McDonal	.d/husbar		LWash	A St	n; DC	20	019			
Page 1 ament of Hant of Hant of Hury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation		tate ce	metery, cren	sition (Name on natory or othe	r place)	7/5	5/10		Location - City or	
permit. Pa Departme Importan any injun once.	-	4 Donation 5 Other (S) 21. Signature of Funeral Service Li	**	Rive			k Cre				<u>verdal</u> lwards	
permi Depar Impor any ir	ŀ	Januce	Edwar	de					_			Md.20746
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that can nly one cause on each	used the death.								Approximate Interval Between
Physician/ Medical	ı	Immediate Cause (Final disease or condition resulting in death)	_aBc	east	Can	ces						Onset and Death
Examiner		resulting in death)	Due to (or	as a conseque	ence of):							
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	ence of):							
ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c									
ia e ia e		resulting in death) Last	Due to (or	as a conseque	ence of):							
icate be exe physician s the burial	edic		d									
ath certific attending p		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnan	cy death 3	Ectopic pred	ináncy				23d. Date of de	livery
death	/sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nt at time of de		Other (speci					Month	Day Year
that the des	Ę.	Part II. Other significant conditio	ns contributing to dea	th but not resu	Iting in the u	nderlying cau	se given in Pa	rt I.	23e. Did	tobacco	use contribute to	the cause of death?
n sign	Completed by								1 🗆	Yes 2	2 ₽ No 3 □ P	robably 4 🗆 Unknown
ław requires has been się e 2 should b	plet								24a. Was			topsy findings available completion of cause of
sician: The la certificate ha irector, page 2	Som								perf	ormed?	death?	2 1 No
ician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:				6. Place of De	eath (Che	ck only one)			
Phys rr this eral dir	음	27. Manner of Death	28a. Date of	patient 2 🗆 E injury 2	28b. Time of		Injury at	Nursing H	ome 5 Res		6 Other (Spec	ify)
ath. r: Afte	icat	1 Natural 5 Pending 2 Accident Investig	ation	Day, Year)	injury		work? 1 🗌 Yes 2	□No		,		
or Atte fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 28e. Place of	Injury - At hon, etc. (Specify)	ne, farm, stre	et, factory, of	fice		28f. Location (ral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	edical (29a, Certifier 1 Certifying	Physician: To the bes	t of my knowle	dge, death o	occured at the	time date an	d place a	and due to the co	auge(g) a	and manner as sta	ated
n 24 h	Medi	(Check 2 L Medical Ex	xaminer: On the basis Nurse Practioner: To	of examination.	and/or invest	igation, in my	opinion, death	occurred:	at the time, date	and plac	e, and due to the	cause(s) and manner state
To the com		29b. Signature and title of certifier	/1 0 0				cense number				ate signed (Month	
11		- Donel	mega	nter		D	5 28	15		6	128/2	010
RT		30. Name and address of person was Daniel Alexa	nder, mo.	12700	23a) (Type, P	rint) Ilœs I	Promi:	se D	r. Bo	DWI	E, MD.	20720
State Registra	~	31. Date filed (Month, Day, Year) JUL 0 1 2010	Serves 32. Reg	istra s Signado	and				,			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22085 Reg. N Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day John Robert Hopkins 2010 June 5:05a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 106 Creswell Ave. E1kton Ceci1 . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Days Hours Min (Month, Day, Year) 220-42-7997 65 **Director** DE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland Ħ Director 10d. Inside City Limits "natural", or items 23a or 28a-f s 1 XYes 2 ☐ No Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 106 Creswell Ave. 21921 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ $\partial \wp \wp \omega$ Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates. 1962–68 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the angles. Extruder Wire & Cable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William R. Hopkins Helen E. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Hopkins/ sister 106 Creswell Ave. Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/5/2010 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Elkton, MD 4 ☐ Donation 5 ☐ Other (Specify) Immaculate Conception Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility R.T. Foard and 259 E. Main St. Gee ELkton, MD 21921 23a. Part 1. Enter the disease, or commoditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, ner il any, leading to in modules cause. Enter Underlying Cause (Disease or linjury Durity Carne a nonescusa necon transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Year 2 No g Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury l X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, only one 29b. Signature Day, Year)

Registrar
DHMH 17 Rev 7/2009

OVE

31. Date filed (Month, Day, Year)

me and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

Triangle, Virginia 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 20872 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death MINUTES THROMBU-EMBOLI ARTERIAL DISEASE 23d. Date of delivery Dav 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 024773 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 MEDICAL CENTER DR. ROCKUILLE, MD

22086

9. Birthplace (State or Foreign

10d. Inside City Limits

1X Yes 2 No

Montgomery

1052 AM

State Registrar ROBERT

MD

32. Registrar's Signature

Charm

Fox

10-04955	
Lawrence	Hazley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 22087

		1- For State	,	Cer	tificate of	Death			Reg. N	lo.		
Physicia		Registrar 1. Decedent's Name (First, Middle,La	st)					2. Date of		_		3. Time of Death
edical Exami		LAWRENCE JOHN H	AZLEY, JR.					July 2	, 2010	y rear		0617 hrs
		4a. Facility Name (if not institution, gir	ve street and number)		4	b. City, Town, o	or Location of	f Death		4c. County of		
		Prince Georges Hospital	Center			Largo				Prince G	eorge	's
Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. la	st birthday)	If Under 1 Ye			of Birth(M	M/DD/YYYY)	9. Birt Foreig	hplace (State or
Director		577-19-5088 1E	ым 2∏ғ 26		Yrs.	Months Da	ys Hours	Min. JUI	NE 4.	1984		intry) DC
		Usual Residence of Decedent										
any		10a. State 10b. County		10c. City,	Town or Location	on						10d. Inside City Limits
≱ .₁	_	MD PRINCE G	EORGES	UPPI	ER MARL	BORO						1 🚼 Yes 2 No
Maryland r 28 a-f show ed at once.	윉	10e. Street and Number				10f. Zip Code			10g. C	itizen of Wha	at Coun	try?
ne Ma or 28	Director	12811 WHITE HOLM	I DDTVE			2077	/.		IIN	ITED S	тдт	FS
vith th		12011 WILLE HOLF.	12. Was Decedent	Ever in U.S	S. 13. Was			in? (Specify Yes				can Indian, Black,
ath v item	Funeral	1 Never Married 2 Marrie	d Armed Forces?	* No	If Ye	es, specify Cuba	an, Mexican,	Puerto Rican, etc	.)	White,	etc.	
ter d		3 Widowed 4 Divorce	d If Yes, Give Year	NO NO	1	Yes 2 N	o specify:			Specify:	$_{ m BL}$	ACK
urs a tura amin	d b	15. Decedent's Education (Specify of	or Dates: only highest grade com	pleted)				ind of work done	16b	. Kind of Bus	iness/Ir	ndustry
215-0036 be filed within 72 hours after death with the Maryland half Hygiewie. hed other than "natural", or items 23a or 28a-faheent, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during mo	st of working lif	e. DO NOT C	use retired)				
036 ithin ne.	립	12yrs			NOT E	MPLOYED						
5-003 iled withi Hygiene. I other th	Ŝ	17. Father's Name (First, Middle, Last	1)				100	s Name (First, Mic	dle, Maid	en Surname)		
2121 uld be fil Mental I marked	Be	LAWRENCE J. HA						NA CAUL				
- 0 D 2 1	ပ	19a. Informant's Name/Relationship (ber or Rural Route				
MD d 2 sh lth an n 27 i		DONNA HAZLEY / MC	THER					DRIVE UP				
ore, healt of Healt litem		20a. Method of Disposition 1 Burial 2 Cremation 3	# Removal from Sta		Place of Disposi rematory or oth		emetery,	Date	20	c. Location -	City or	lown, State
Pages ent o		Donation 5 Other Specific		WA	SHINGTO			7/9/2010				MARYLAND
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traun	(21. Signature of Funeral Service Live		11	22. N	ame and Addre	ss of Facility	JOHN T.	RHIN	ES FUN	ERA	L HOME, LLC
E E E E	9 (0)	Julies	icell	V				E WASHIN				0.
Physician		36a. Part I. Enter the disease, or com failure. List only one cause on e	plications that caused	he death.	Do not enter th	e mode of dyin	g, such as ca	ardiac or respirato	ry arrest, s	shock, or hea	rt	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease a	W	itis								Death
LAdillilei	-	or condition resulting in death)	Due to (or as a conse	quence of):							
	_	Sequentially list conditions,	Due to (or as a conse	auonno of	۸.				_		_	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		quence or	1.							
	хап	(Discass or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):		_					
cuted and trans			ı									
760, cate be executed physician and the burial - transi	/Medical	X UNPENDED	AMENDED 23	la,27	per me	g906 8	- 9-10	vt				
760, icate be extphysician the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of pregr					:	23d. Date of	•	
K 68	/sician/	past 12 months?	1 Live birth Pregnant at	time of dea	nth =		Ectopic	pregnancy		Month	L	lay Year
Box death c the atten ed for us	/sic	1 Yes 2 No 9 Unknow	- L		atn 5 Oth	er (Specify)			- 4			
D. B. the de by the	Phy	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	nderlying cause	given in Par	rt I. 23e.	Did tobac	co use contrib	bute to	the cause of death?
P.O. ires that 1 signed b	þ							1	Yes 2	No 3	Prob	ably 4 🗸 Unknown
ds, equire	Completed								Was an	24b. W	Vere au	topsy findings available
of Vital Records, ng Physician: The law require the true continue has been sinneral director, page 2 should be neveral director, page 2 should be the continue of the control of the contr	Jp.							_ _	autopsy perform <u>ed</u>	<u>1</u> ? d	eath?	ompletion of cause of
Re(The icate	Ö								Yes 2	No 1	✓ Ye	s 2 No
tal certif ector,	Be (25. Was case referred to medical examiner?	Hospital: 1 Inpatie				IOthor:	Check only one)			7	
Physic al dir	²	1 ✓ Yes 2 No	T		ER/Outpatient		iury at Work?	Nursing Home		idence 6		
Afte funer	Ë	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injui (Month, Day,Ye		28b. Time of Ir	' ' I _	Yes 2		cribe now	injury occurre	au .	
sior trend death ctor: y the	atic	2 Accident Pending										15 1-11 - 1- Cit
Division tal or Attendia rs after death.	ţį	3 Suicide 6 Could no		ury - At ho	ome, farm, stree	t, factory, office	building, etc		tion (Stree wn, State)		er or Ru	ral Route Number, City
Dj spital nours a neral l	Certification:	4 Homicide determine										
n 24 h	cal	(Ontook only	cian: To the best of my er:On the basis of exar									
Division of Vital Records, P.O. Box 687 To the Bospital or Attending Physician: The law requires that the death certifit within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	ledical		and manner stated	anon a			nse number					nth, Day, Year)
	Σ	29b. Signature and title of certifier	11 11							uly 3, 2010		, <i>50</i> , 100/
Na		4,	NVI, CE			0.0	.M.E.			ury 3, 2011		
41		30. Name and address of perso, who				n C++ D	altino a s = "	MD 24204				
		Jack Titus MD. Deputy	Chief Medical Ex			n Street, Ba	aitimore, N	VID 21201				
Segis	tate	31. Pate filed (Month, Day, Year)	32. Registrar	s Signatu	re							

10-04982 John L. Hall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 22088

		1- For State Certificate of Death Reg. No.									
Physici		1. Decedent's Name (First, Middle,Last) 2. Date of Death Mostly 3. Time of									
Medical Exami	ner	John Leonard Hall July 3, 2010	hrs								
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Hospital Center 4c. County of Death Cheverly Prince George's									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (S'	tate or								
Director		577-80-4837 1 M 2 F 52 Yrs. Months Days Hours Min. April 19, 1958 Country D									
		Usual Residence of Decedent									
any		10a. State 10b. County 10c. City, Town or Location 10d. Insid	de City Limits								
Maryland 28a-f show d at once.	ŏ	Maryland Prince George's Landover	es 2 No								
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Deparment of Heathh and Mental Hyggiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Diç	7401 Village Green Terrace 20785 United State	es								
t be n	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian White, etc. frican	, Black,								
er dea or it	Fur										
irs afte .uraf*	l by	or Dates:	111								
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)									
036 ithin ithin ne.	фu	12th Warehouse Worker Privat	:e								
5-0 lled w Hygie											
121 d be fi lental arked svent,	Be	Leon Hall Barbara Jean Tatum									
D 2 shoul and M	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Alisha Danita Henry/ Daughter 7401 Village Green Terrace Landover, Md. 2	20785								
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatic event, the Medica		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State									
nore n of F		1 X Burial 2 Cremation 3 Removal from State crematory or other place) Maryland National July 13,									
Itin Bit. Pa artmen ortan	1	Maryland National 2010 Laurel,									
Dep Tinju			019								
Physician		23à Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									
/Medical Examiner		Yallure. List only one cause on each line. End Stage Renal Disease with Bleeding from Immediate Cause (Final disease a. Dialysis Shunt									
		or condition resulting in death) Due to (or as a consequence of):									
	ē	Sequentially fist conditions, if any leading to immediate Due to (or as a consequence of):									
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated c.									
ted - nsit	Exa	events resulting in death) Last Due to (or as a consequence of):									
760, ficate be executed g physician and the burial - transit	<u>s</u>	x unpended x amended 1,23a,27,28a-f per me g906 8-10-10 vt									
760, ficate be g physici the buri	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery									
687 ertifica ding p		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year								
Box 68's death certification of for use as	Physician	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)									
O. B the d	된	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the cau	of death?								
P.O. res that the signed by t	ð	1 Yes 2 No 3 Probably 4	Unknown								
ords, w requir	Completed by	24a. Was an 24b. Were autopsy findir									
e law e has ge 2 sh	ď	autopsy prior to completion performed? death?									
tal Rec		25. Was case referred to medical 26 Place of Death (Check only one)	No								
Vital F ysician: '	e Be	examiner? 1 V yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other:									
ing Ph. After th	2	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred									
itendi leath. tor: /	aţie	Natural 5 Pending Pending Investigation 7-3-10 5:30 am 1 Yes 2 X No Bled fom Dialysis Shun	it								
Division of Vital Records, P.O. pital or Attending Physician: The law requires that th ours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route No. 7401, Vi.11ago	lumber, City								
Bospital Funcal Funcal cely filled		4 Homicide Terrace Hyattsville,	Md.								
	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	ļ								
To the within To the complet	Medi	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Ye									
12		July 4, 2010	/								
4	-	30. Name and address of person who completed cause of death (Item 23a)									
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
St	ate	31. Date filed (Month Days) 32. Register's Signature									
Regist		ANT A CALA TENNE IN THE									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		Cei	rtificate of L			Reg. No 20	10	22089	
П	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death	
	Medic	al	Melanie Gay	Johns	ton	T		July		20°10	6:50 a. ^M	
	Examin	er	4a. Facility Name (If not institution, give st St. Mary 's Hospi				r Location of Deatl ard town	1		y of Death • Mary	v's	
• • •	Funeral		5. Social Security Number 6. Sex	7. Age (I)	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.		th	9. Birthp	lace (State or Foreign	
	Director		136-40-8581 Usual Residence of Decedent	M 2 % F	51 Yrs.	WOITHS Days	Hours Min.	11/19	71958	Count	Utah	
	and show at	or	10a. State 10b. County	1	0c. City, Town or Lo	cation		-		11	0d. Inside City Limits	
	Maryla 28a-f	Director	Maryland St. Mary	y's	Cali	fornia				1 ☐ Yes 2 🛣 No		
	th the	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?	
	ath wit	Funeral	45540 Baringer Dr	ive 2. Was Decedent Eve	rin 110 10 1		619	anife Van au Na		S A		
9	er de: or ite miner	by F	1 ☐ Never Married 2 X Married	Armed Forces?		Was Decedent of Hi If Yes, specify Cuba		o Rican, etc.)		ce - America ck, White, e		
003	urs aff :ural", al Exa	ted	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2🌠 No	Specify:		Specify	" Wh	ite	
15-	72 ho n "nat fedica	Completed	15. Decedent's Edu (Specify only highest grade		i (Give	dent's Usual Occup- kind of work done o		king	16b. Kind of E	Business Ind	lustry	
212	vithin jiene. er thai		Elementary/Seconday (0-12)	College (1-4 or 5+)	iire. D	O NOT use retired) Secreta:	rv		County	Gove	rnment	
nd	filed all Hyg	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Surnam	e)		
Уlа	Ild be Ment narke	잍	Robert Wood				Mar	ilyn S	hepard			
Mai	2 shorth and 27 is not traum		19a. Informant's Name/Relationship (Type			ng Address (Street a						
re,	f Heal item other	المم	Thomas A. Johnsto		20b. Place of Dispo	40 Baring	:	Date	20c. Location			
<u>m</u>	Page nent o ant: If Iry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place e1d-Echo1		06/2010	Charlo	tte H	Mall, MD	
Bāltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signate of Fareral Service Acenses			2. Name and Addres						
	<u> </u>		Edward N. Brinst 23a. Part 1. Enter the disease, or complice	ield, JR.		22955 Ho				m, MD		
	Physician/		shock, or heart failure. List only one Immediate Cause (Final							1.00	Approximate Interval Between Onset and Death	
	Physician/ Medical		disease or condition resulting in death)	Due to (or as a co	Donseque de of):	Chilylon	Carnic	Respira	y Fell	04		
	Examiner	L	Geographic list conflictor	ARDS	5 .	240						
-	p #	nine	if any, leading to immediate cause. Enter Underlying	Due to (or as a co								
	ecute and I-trans	Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):							
0		Medical	U _d	Lung	Cancer	•						
	ag ag ∰		IF FEMALE:									
9 X	ath cer attendi	ian/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of p	Fetal death 3	Ectopic pregnanc	у			ate of delive	ry Day Year	
Box	The law requires that the death cert ate has been signed by the attendir page 2 should be detached for use	Physician/	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne or death 5 L	Other (specify)					buy rour	
P.O.	that the	by P	Part II. Other significant conditions cont	ributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to the	e cause of death?	
Division of Vital Records,	v requires the been signer should be							1 2	Yes 2 No	3 🗆 Prob	ably 4 🗌 Unknown	
000	has be be 2 sh	Completed						24a. Was a	sy	prior to con	sy findings available npletion of cause of	
H.			25. Was case referred to medical					1 \(\text{Yes}		death? 1 🗌 Yes	2 No	
Vita	or Attending Physician: after death. Director: After this certific in by the funeral director,	To Be	eyaminer?	espital:	2 ER/Outpatier	Otho	ace of Death (Chec	ok only one) ome 5 ☐ Resid	lance 6 0 0th	(C0/f)		
0	ter this		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of injury (Month, Day, Ye	28b. Time of	28c. Injury work	at	28d. Describe h				
0	tendii Jeath. tor: At the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 ☐ No					
<u>SIN</u>	lor At after o Direct I in by	Cert	4 Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural i	Route Number,	
	To the Hospital or Attending Physics within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier 1 Certifying Physic	ian: To the best of my	knowledge, death o	occured at the time,	date and place, a	nd due to the cau	use(s) and mann	er as stated	1.	
:	the H(Mec	(Check 2 Medical Examine only one) 3 Certifying Nurse	r: On the basis of exam	ination and/or invest	igation, in my opinio	n, death occurred a	at the time, date a	nd place, and du	e to the cau	se(s) and manner stated.	
,	or viti		29b. Signature and title of certifie	Alch	1. n	29c. License			29d. Date signe			
			30. Name and address of person who con	pleter Guise of death	1 (Item 23a) (Type, P		60473		07/02	./ XO	l U	
do	-		St. Mary 1) Hoy	ital Le		en mo	2065	50				
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	/						

			State of Maryland / D State of Maryland / D Registrar		ment of H <i>icate of D</i>		-	giene _{Reg. N} 2 ()	10	22090	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of De June		2010	3. Time of Death 02:00 P M	
	Medic Examin		Josephine A. Kay 4a. Facility Name (if not institution, give street and number)	4t		ocation of Death	Julie	4c. Cour	ity of Deat	h	
J			Prince George's Hospital Center 5. Social Security Number 6. Sex 17. Age (In yrs. last birth.	iday) If	Chever1	y If Under 24 Hrs.	8. Date of Bird			orge's	
	Funeral Director		247-09-7369 1 □ M 2 🖾 F 92 Y		onths Days	Hours Min.	03/14/	1918		th Carolina	
	and show at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location	on					10d. Inside City Limits	
	Maryla 28a-f	irect	Maryland Prince George's Landove		10f. Zip Code					1 ☐ Yes 21 No	
	vith the 23a or st be n	Funeral Director	10e. Street and Number 2404 Greeley Place	of What Co							
	death v items ner mu		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was	20785 Decedent of His s, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Amei lack, White	rican Indian,	
036	s after ral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Å No If Yes, Give Year or Dates.	1 🗆	Yes 2 XNo	Specify:		Speci		ack	
15-0	72 hour "natu ledical	Completed	(Specify only highest grade completed)	(Give kind	's Usual Occupa I of work done du	tion uring most of work	ing	16b. Kind of	Business	Industry	
212	within giene. er thar , the M		Elementary/Seconday (U-12) College (1-4 or 5+)		ot use retired) es Press	er		Laundr	`у		
Maryland 21215-0036	ige 1 and 2 should be filed wint of Health and Mental Hygint: If item 27 is marked other or other traumatic event, to	To Be	17. Father's Name (<i>First, Middle, Last</i>) John Payton			18. Mother's Nam Tillie	•	Maiden Surna	me)		
aryl	hould that we want we want we want was wark in marking the wark in marking was wark wark wark was wark wark wark wark wark wark wark wark		, State, Zip	o Code)							
S ô	and 2 s Health a em 27 i	1	Arthur Kay/Grandson 240 20a. Method of Disposition 20b. Place of			lace, La		Mary 1a			
mor	ent of F ent of F nt: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery	y, cremato	ory or other place) ark 06/23	Date :	Laurel	•		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur / Fineral Service, Linnsee	22. Na	ame and Address	of FacilityGeo	rge P.	Kalas F	uner	al Home	
	0.0 = 0 0		23a. Part 1. Enter the disease, or complications that caused the death. Do no			ons Isla: , such as cardiac			ter,	Approximate	
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition HYPOXEMIC RESPIRATORY FAILURE TO DAYS											
	Medical Examiner		resulting in death) Due to (or as a consequence of UPPER AIRWAY)	f):						7 DAYS	
	- #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	•							
	xecuted and al-trans	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last		LOMAS					7 DAYS	
09	cate be executed physician and the burial-transit	edical	d								
<u> </u>	eath certifica attending p I for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy					23d. l	Date of del	livery	
Division of Vital Records, P.O. Box 687	death o	Physician/M	in the past 12 months? 1		ctopic pregnancy ther (specify)				Month	Day Year	
P. O.	es that the des signed by the s be detached t	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the unde	erlying cause give	en in Part I.	23e. Did t	obacco use co	ntribute to	the cause of death?	
ds, l	requires t been sign should be	ted b	Renal Insufficiency				1 🗆	Yes 2 No	3 🗆 P	robably 4 🔼 Unknown	
ecol	e law re thas be ge 2 sh									ntopsy findings available completion of cause of	
a B	ian: The rtificate ctor, pag	Be Co	25. Was case referred to medical examiner?		26. Pla	ce of Death (Chec		2 ▼ No	1 L Yes	s 2 No	
fVit	Physic this ce al direc	은	1 ☐ Yes 2 ☒No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out 1 ☐ Inpatient 2 ☐ ER/Out 27. Manner of Death 28a. Date of injury 28b. Ti		3 DOA Other	4 □ Nursing Ho	ome 5 Resi			cify)	
o uo	ath. r: After ne fune	1									
N Si	or Atte after de Directo in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, street,	factory, office		28f. Location (S City or Tox		nber or Ru	ral Route Number,	
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, d (Check 2 Medical Examiner: On the basis of examination and/or	death occu	ured at the time,	date and place, and death occurred a	nd due to the ca	ause(s) and ma	nner as sta	ated.	
	o the Pvithin 24 o the Footbet	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowle 29b. Signature and title of certifier			time, date and place			manner as	stated.	
	->-0		> Kenny	_	D162	73		JUNE	23, 2	2010	
	40		30. Name and address of person who completed cause of the ath (Item 23a) (Tevathy Murthy, 6130 Landover Road,	ype, Print Che	everly,	Maryland	20785				
	Stat Registra		31. Date filed (Month Pay, Year) 2010 32 Registrar's Signature	hou	u.J		-	·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dona1d Ledbetter Lee Ju₁y 2010 4:40 p.m. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F (Month, Day, Year) 04/01/1938 Months Days Hours Min **Director** Yrs. 233-60-0057 72 West Usual Residence of Decedent Show 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits or 28a-f 1 X Yes 2 No Maryland | St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 22680 Cedar Lane Court, Apt. 2212 20650 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: Year or Dates White and Mental Hygiene.

is marked other than "natur aumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Store Manager Auto Parts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Daniel L. Ledbetter/Son 1611 Archie's Place, Hughesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 07/07/2010 | Charlotte Hall, MD Edward N. Brins: 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr Approximate shock, or heart failure. List only one cause of Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or es a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a P.0. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed? Yes 2 1 No 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? H88Bece 1 🗌 Yes Other: Certificate: To 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natura 2 Accident Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical Signature and title of certific 29b. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

0. Name and address

31. Date filed (Month, Day, Year)

James

C. Boyd,

8

41680) Miss Bessie Drive, Leonardtown,

MD

20650

of person who completed cause of death (Item 23a) (Type, Print)

			1 - State of M Registrar	larylanc	•	rtment of F tificate of E		Mental Hy	giene Reg. No	2010	22092		
	Physicia		1. Decedent's Name (First, Middle, Last) Robert James Lake					2. Date of De June			3. Time of Death 11:05 PM		
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death Annapolis					c. County of Death			
'سهر	Funeral		130 Hearne Road, Apt. 1014 5. Social Security Number 205-28-1133 6. Sex 1 X M 2 F	ge (In yrs. las	***	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth	g. Birth	place (State or Foreign		
	Director ≥		Usual Residence of Decedent		Yrs.			09/28/	1937		sylvania		
	aryland ka-f sho ified at	ector	Maryland Anne Arundel		Town or Loc apolis						10d. Inside City Limits 1 Yes 2 No		
	th the N 3a or 26 t be not	al Dir	10e. Street and Number			10f. Zip Code				itizen of What Cou nited Sta			
	leath wi Items 2 er musi	Funeral Director	130 Hearne Road, Apt. 1014 11. Marital Status 12. Was Decedent				21401 Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,			14. Race - Ameri	can Indian,		
036	be filed within 72 hours after death with the Manyland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 Married 3 Widowed 4 Divorced Year or Dates.	No No		Yes 2 No		no moun, c.c.,		Black, White, Specify: Whi			
15-0	72 hour n "natul fedical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occupa ind of work done of NOT use retired)		orking	16b. I	Kind of Business In	ndustry		
212	d within ygiene. her tha nt, the N	Be Cor	Elementary/Seconday (0-12) College (1-4 or 2	5+)		Employed					ontractor		
land	2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, Last) Amos Lake					ame (First, Middle Gottsabe		Surname)			
Maryland 21215-0036	2 should be the and Ment 27 is marked traumatic e		19a. Informant's Name/Relationship (Type, Print) Deborah Murphy Lake-Wife			,				r Town, State, Zip			
ore,	1 and of Hea fitem		20a. Method of Disposition 1 Burial 24 Cremation 3 Removal from State		ace of Dispos	sition (Name of atory or other plac	e)	Date	20c. L	ocation - City or T	own, State		
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee			ematory Name and Addres			/2010 Edgewater, Maryland ge P. Kalas Funeral Home				
ñ	Dep Imp any	1. //	23a. Part 1. Exter the disease, or complications that cause		2	973 Solor	nons Isl	and Rd.	Edge	ewater, M	ID 21037		
7	Physician Medical Examiner		shock or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death) a. I'ue to (or as		lus	Di CAM	20	02	- 19	NE	Approximate Interval Between Onset Ind Death		
09	e be executed ysician and e burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as										
. Box 6876	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant g ☐ Unknown	2 □ Fetal at time of de	death 3	Ectopic pregnand Other (specify)	у			23d. Date of delive Month	very Day Year		
ds, P,O	luires that the signed by all doe deta	by	Part II. Other significant conditions contributing to death	but not resu	Iting in the ur	nderlying cause giv	en in Part I.			use contribute to	the cause of death?		
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Viita	nysician lis certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpa:	tient 2 🗆 E	ER/Outpatien	Othe	ace of Death <i>(Cl</i> er: 4 \(\sum_\) Nursing		idence	6 ☐ Other (Specif	5y)		
28b. Time of injury at work? 28c. Injury at work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred work?													
Division of Vital	or Atter after des Director in by th	Certificate:	3 Suicide 6 Could not be 28e. Place of In	jury - At hon tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location City or To		nd Number or Rura e)	al Route Number,		
Ω	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of the conly one) 1 Certifying Nurse Practioner: To the	examination	and/or invest	gation, in my opinio	n, death occurre	d at the time, date	and plac	e, and due to the ca	ause(s) and manner stated.		
	Song the son	_	29b. Signature and title of certifier			2 0s. License		/		ate signed (Month,			
	*44.2		30. Name and address of person who completed cause of	1170	(4)	ugstre	RS#	105 F	T. U.	4 shugh	24706 an Co		
	Sta Registra		31. Date filed (Month, Day, Year) JUN 2 5 2010 32. Regist	far's Signatu	A. 160	ake							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 22093 State of Maryland / Department of Health and Mental Hygiere U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Month June Margaret 24 В. Lloyd A^{M} 2:00 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bradford Oaks Nursing Home Clinton Prince George's Social Security Number 6. Sex Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛂 F Months Davs Hours Min. March 21, 77 578-48-5711 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 X Yes 2 No Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7520 Surratts Road 20735 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Black, White, etc. Armed Force 1 \square Never Married 2 \square Married 1 ☐ Yes If Yes, Give 2 No 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th United States Postal Service Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jessie Williams Nelly Wooden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 99 56th Street SE Dameon Lloyd/ Grandson Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Washington, DC 21. Si nature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. icensee 20019 4001 Benning Road NE Washington, DC 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Community Acquired Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav Year Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 A No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 Yes 2 No Accident Investigation

28f. Location (Street and Number or Rural Route Number.

29d. Date signed (Month, Dav. Year)

20602

City or Town, State)

Examiner Box 68760 P.O. Division of Vital Records,

Physician/

Medical

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Physician/

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Certificate:

29a. Certifier

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral: State

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of ceptifie 29c. License number ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who M.D. 12070 Old Line Centre Suite 207 Louis V. Kaufman Waldorf, Md. 31. Date filed (Month, Day, Year) 1 2010

32. Registrar's signatu

6 Could not be

determined

DHMH 17 Rev 7/2009

Registrar

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

		-	State of Maryland / D.	ppartment of Health and N Certificate of Death	1ental Hygi ห	ene -9. N2 0 1 0	22094				
	Physicia		1. Decedent's Name (First, Middle, Last) Myrtle Lee Mi		2. Date of Death Month	Day Year	3. Time of Death				
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	aug	4c. County of Deat	h				
	Funeral		5. Social Security Number 6. Stx 7. Age (In yrs. last birtho	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Baltimore 9. Bird	thplace (State or Foreign				
	Director		557-32-6027	s. Months Baye Hours Minn	₹%15°/13°2	18°′ Ma	ryland				
	iryland a-f shov ied at	ctor	10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits 1 ☐ Yes 2X☐ No				
	a or 28¢ be notif	al Dire	MD Montgomery Burtons 10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co					
	eath with	Funeral Director	3918 Dustin Rd. 11. Marital Status 12. Was Decedent Ever in U.S.	20866 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ame	rican Indian,				
903	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	e, etc. nite					
:1215-(Completed	(Specify only highest grade completed) (CEIementary/Seconday (0-12) College (1-4 or 5+)	ecedent's Usual Occupation Give kind of work done during most of work e. DO NOT use retired) Homemaker	ing	16b. Kind of Business Industry Domestic					
land 2	d be filed w Aental Hygi rrked othe	To Be	17. Father's Name (First, Middle, Last) Harry Edward Mulligan	18. Mother's Nam Nora Lee		laiden Surname)					
Mary	2 should the and he straims			Mailing Address (Street and Number or Rura 12 Inaugural Way, Montgor			o Code)				
Baltimore, Maryland 21215-0036	Page 1 and nent of Heal int: If item ? iry or other		20a. Method of Disposition 20b. Place of E		Date	20c. Location - City or Falls Church,	- City or Town, State				
Balti	permit. Departn Importa any injt		urch, VA 22042								
-1	hysician/	0.5	23a. Part 1. Enter the disease, or complications that caused the deam. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	enter the mode of dying, such as cardiac of	or respiratory arres	st,	Approximate Interval Between Onset and Death				
	Medical Examiner		resulting in death) Due to (or and a consequence of)	unteres burness	amet	-					
	sit sd	Examiner	Couperficially list conditions if any, leading to immediate cause. Enter Underlying	a den dis	PASE						
	execute ian and irial-tran		Cause (Disease or linjury that initiated events resulting in death) Last		715C						
200	icate be pphysic s the bu	ledical		Sclerosis							
Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be executed that Ab hours after death. Lat hours after death. the Funeral Director, After this certificate has been signed by the attending physician and the Funeral Director, page 2 should be detached for use as the burial-transit mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year				
Division of Vital Records, P.O.	requires that the dec been signed by the a should be detached	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		eacco use contribute to	0.4				
Record	The law req ate has bee page 2 shor	Completed			24a. Was ar autops perform 1 🗆 Yes 2	y prior to death?	ntopsy findings available completion of cause of s 2 □ No				
/ital	Physician: The lav r this certificate has aral director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Hospital: 2 ☐ Hospital: 3 ☐ Hospital: 4 ☐ Hospi	26. Place of Death (Check		nce 6 Other (Spec	cify)				
The state of the s											
Divisi	reet and Number or Ru , State)	iral Route Number,									
	ie Hospi n 24 hou ie Funer bleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de control of the control	nvestigation, in my opinion, death occurred a	t the time, date and	d place, and due to the	cause(s) and manner stated.				
	To the vithin comp	-	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mont	h, Day, Year)				
			30. Name and address of person who completed cause of death (Item 23a) (Ty	0)062575 A		JNIX I	2010				
	Stat	· A -	31. Date filed (Month, Day, Year) 22. Registrar's Signature	h Kutaw Street	r#502	tal timen	2, NO 21201				
	Registra		JUL 152010 Senter S. A	ark							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 25 Jeffrey D. Mover June :20 p. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 918 Pontiac Avenue Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 DXM 2 D F Months Hours Maynth 13, Ye 1953 Mary Yand Director 214-62-1138 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 918 Pontiac Avenue 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1√Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2XX No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene.
I other than "
event, the Mer during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Sales Manager automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H item 27 is marked ot other traumatic ever ္ဝ Duane G. Moyer Mary Gorrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Ruth Moyer - wife 918 Pontiac Avenue, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2xxxCremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important; If any injury or once. Stauffer Crematory 6-28-2010 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) ADENOCARCINATIA OF PANCHEAS set and Death Physician/ Medical Examiner Sequentially list conditions Examine Due to for as a consequence of If any, leading to immedicause. Enter Underlying the attending physician and thed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the atte Day Pregnant at time of death 1 Wes 2 L 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No e Hospital or Attending Physician: 7 24 hours after death.

Funeral Director: After this certifice completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 2V Accider
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifie

3+1

State Registrar 501

SEVENTH ST. FREAERICK MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CON

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Arlene McKenzie 8:108 /Medical 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lions Center Cumberland Allegany 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F Months Hours Min. 215-42-4321 **Director** 66 Maryland May 31, 1944 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, It a Medical Executary traust be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 KYes 2 No Allegany Maryland Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Baltimore Street 21501 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 M Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Be Completed by Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banker Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Staup Clementine Duckworth ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James McKenzie - Husband 205 Baltimore Street, Cumberland, Maryland, 21501 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department or important: if any injury or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park July 02, 2010 Frostburg, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. & Sondi Willam 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) 6months End /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. En of Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? 2 **N**0 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h Rol, Cumberland State Registrar

DHMH 17 Rev 1/2001

10-04808 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 22097 Robin Elaine Massev State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar I. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Month Day June 26, 2010 ROBIN ELAINE MASSEY **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ft. Washington Hospital Fort Washington Prince George's 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Months Davs Hours Director Country) DC 1 M 2X F 579-78-5786 53 12-30-1956 Usual Residence of Decedent iny 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show must be notified at once. Prince George' MD Oxon Hill Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5808 Spokane Drive 20745 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married 1 Yes Black 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: ₹ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Clerk Private Industry 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Randolph Massey Gloria Trivers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5808 Spokane Dr., Oxon Hill, MD 20745 Ronald Carson/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: injury or oth 07-01-2010 Suitland, MD Lincoln Mem. Cem. Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Cedar Hill FH,4111 PA Ave.,Suitland, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical Immediate Cause (Final disease Methadone intoxication Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760,

3. Time of Death

2035 hrs

10d. Inside City Limits

1 Yes 2 No

Approximate Interval

Between Onset and

Death

nd ransit	Exami												
After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - transit	Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknown	AMENDED 23a, 27, 28a-f. 23c. If yes, outcome of pregr 1 Live birth 4 Pregnant at time of des 9 Unknown contributing to death but not re	2 Fetal death ath 5 Other (Sp	ecify)	Ectopic pregr	23e. Did tol 1 Yes 24a. Was a autops perfor 1 Yes 2	n 24b. W sy pr ned? de	Day Day Day Day Day Day Day Day	Unknown			
iis ceri directo	œ l	examiner?											
	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury Fd 7:35 pm		ry at Work? Yes 2 X No	unk	ow injury occurre					
ours after o	ertification	3 Suicide 6 X Could not be determined	e 28e. Place of Injury - At ho (Specify) house	ome, farm, street, factor	28f. Location (S or Town St OXON H	28f. Location (Street and Number of Rural Route Number, (or Town, State) 5808 Spokane Dr Oxon HIII, MD							
within 24 hours after death. To the Funeral Director: completely filled in by the	Medical C												
≯ F 3	§ S	29b. Signature and title of certifier	and marmor stated	29	c. Licens	se number		29d. Date signe	d (Month, Day, Ye	ear)			
4		Panich Routhell		June 27, 2010									
.		30. Name and address of person who completed cause of death (Item 23a)											
		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
St Regist	ate rar	JUL O'M' 2010 ar	32. Registrar's Sistan										
Rev 1/20	001			ORIGINAL									

10-04802 James Mannix Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Mannix		amend # 🕏	ate ^r of Maryla		artmen rtificate			and	Menta	al Hyg		leg. No.	201	0	22098
Physiciar	1/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year											3. Time of Death		
ledical Examin		JAMES MAN 4a. Facility Name (if not institution	NIX	ımber)		June 26, 2010 4b. City, Town, or Location of Death 4c. County of Death							10211115		
,		Sinai Hospital Baltimore													
Funeral	T	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda	ay)	If Under 1				8. Date of Bi	rth(MM/I		9. Birth	place (State or
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daryland 28a-f show any 1 at once.	Director	Maryland 10e. Street and Number			ltimo	re	10f. Zip Co	de				10g. Citiz	zen of Wha	t Count	ry?
th the Maryland 23a or 28a-f sho notified at once		4800 Seaton Dr	ive					212	15		United States				
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er dea			1 Yes	2 🔀 No		1 🗆 🕥	res 2 v	No	specify:				Specify: B	100	1-
ours af	함	15. Decedent's Education (Spe	or Dates: cify only highest gra	de completed)		cedent's	s Usual Occ	cupation					Kind of Busi		
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21215-0036 Mental Hygiene. Marked other than 'c event, the Medical	Be	The factor of th	unk											OIII	,
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other that injury or other traumatic event, the Mediumy or other traumatic event, the Medium and the Medi	₽[19a. Informant's Name/Relations									ral Route Nu				
imore, MD 2 Pages I and 2 shou ment of Health and N lant: If item 27 is n or other traumatic		Vanda Gerard /	Daughter	20b.			on (Name of			lve.	Kowla Date	nd H 20c. l	leight Location - (Sity or 1	91748
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629	ł	4 Donation 5 Other \$\int \text{Other } 21. Signature of Funeral Serv e	becify: Licensee	M€	etropo	0 1 1 1 22. Na	tan me and Add	dress o			/2010 Fune		exand Homes		
Balt permit. Departi Import injury	1	KOTHOLW	ima Mi	21085		553	38 Mai	c1bc	oro P	ike	Fore	stvi	11e,	Mar	yland 20747
Physician /Madical.		23a. e. I. Enter the dise us, or fail re. List only one cause	complications that con each line.	aused the death	n. Do not e	nter the	mode of d	ying, su	uch as car	rdiac or r	espiratory ar	rest, sho	ock, or hear	t	Approximate Interval Between Onset and Death
Examiner	İ	Immediate Cause (Final disease or condition resulting in death)		able Car		Ar	rhyth	mia			_	_	_	718	Death
	إ	Sequentially list conditions,	b.	2 202528110222	nf):										
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Box 68760, e death certificate be executed the attending phy sician and ef for use as the burial - transi	edical	X UNPENDED	AMENDED	23a,pt	.II,2	7									
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D. Bc	ڪL	Part II. Other significant condit	9 _ Olikii		resulting in	the un	derlying ca	use giv	en in Part	t I.	23e. Did	tobacco	use contrib	oute to t	he cause of death?
P.O. res that the signed by be detace	2	Hypertensio	-								1 Ye	es 2	No 3	Prob	ably 4 Unknown
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Che law	Completed											ormed?		eath? Ye:	s 2 No
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be.	의	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2	ER/Outpa				at Work?		Home 5 8d. Describe			Other:	
tending Pheath. or: After 1	<u>Ë</u>	1 X Natural 5 Pen	(Mont)	h, Day,Year)			· ·		s 2 1						
IVISION or Attence after death Director:	ertification:		stigation 28e. Plac	ce of Injury - At I	nome, farm	, street	, factory, of	fice bui	ilding, etc.	. 2	8f. Location or Town,		and Numbe	r or Rui	ral Route Number, City
Di spital hours a neral I	ပြု	4 Homicide	rmined (Specify)			_									
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the it.	edical		hysician: To the be miner:On the basis	of examination	dge, death and/or inve	occurri estigation	ed at the tin on, in my op	ne, date pinion, d	and placed death occ	e, and d urred at	ue to the cat the time, dat	use(s) an e and pla	ace, and du	as state ue to the	e cause(s)
To To Con	Med	29b. Signature and title of certific	and manner:	stated.	<u>.</u>				number						nth, Day, Year)
14		(I_{Λ})	MA	1			C	D.C.M	I.E.			Jun	ie 27, 20	10	
'	İ	30. Name and address p rsor	who completed cau			Don	n Straat	Ralei	more A	MD 212	201				
				egi rar's Si sa		reni	n Street,	Daltil	noie, N				<u></u>		
Sta	Uθ	31. Jun file (1/19 1/2 0	[beers	4.	The state of										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22099 1 - State amend#5, per FH, QACHD, 7/1/10, ms Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE So\0 Verna J Novack Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Univ. of maryland Hospita) Ballimore Social Security Number 219-26-7909 **219-26-7929** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Hours oCT***, DZZZ***1939 WEST TO VIRGINIA 70 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MARYLAND QUEEN ANNE'S CENTREVILLE 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21617 UNITED STATES 122 SONATA WAY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 M Married "natural", or Completed by Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify WHITE 3 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) **TEACHER EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) VIRGINIA ANN CALFEE VERNON KITTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 SONATA WAY, CENTREVILLE, MD 21617 EDGAR NOVACK/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHE'S APEARE' CREMATION injury or STEVENSVILLE, MD CENTER Signature of Funeral Service Licenses 22 PELLEONS Addresse Free Bein & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cardio genie shock disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner aartic stenosis Sequentially list conditions, Examine if any loading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialattending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death ed by the a g 🗌 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 0031590 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pinol

Registrar

State

31. Date filed (Month, Day, Year)

JUN 28

Richard	Merrick	Norman	
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		1- For State Registrar		C	ertifica	te of I	Death			R	eg. No.	0,0	<u> </u>
Physicia Medical Examir		1. Decedent's Name (First, Midd Richard Merric		2. Date of Death Month Day July 8, 2010						3. Time of Death 1200 hrs			
		4a. Facility Name (if not institution 1275 Gladstone Aven	-	umber)		- 1	Churchton	Location o		001,9 0, 20	4c. Cou	inty of Deat	
Funeral Director		5. Social Security Number 220-68-6107	6. Sex	7. Age (In yrs	. last birth	day)	If Under 1 Year Months Days	_	r 24Hrs.		*	Forei	rthplace (State or
Director		Usual Residence of Decedent	1 X M 2 F	53		Yrs. Months Days Hours Min. 06/10/1957							ountryMaryland
any	ł	10a. State 10b. County		10c. Ci	ty, Town o	r Location	า						10d. Inside City Limits
Maryland 28a-f show any d.at.once.	5		Arundel		(Chur	chton						1 Yes 2 No
the Mary!	Director	10e. Street and Number 1275 Gladstone	Avenue				10f. Zip Code 207	33		1	Og. Citizen o Unite		
h with	Funeral	11. Marital Status		cedent Ever in	U.S.		Decedent of Hisp					Race - Amer White, etc.	ican Indian, Black,
after deat al", or ite	by Fun	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White Specify: 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No Specify: Specify:									White		
hours natura		15. Decedent's Education (Spe			Usual Occupation				16b. Kind o	of Business/	Industry		
036 thin 72 ne. r than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	М	ason					Mason	ry Co	ntractor
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the <u>Medica</u>	a	17. Father's Name (First, Middle Robert T . Norm	an		. •			Marg	aret	McFad			
MD 21 nd 2 should 1 ulth and Mer m 27 is mar aumatic ev	19b. Mailing Address (Melissa A. Norman/Wife 1275 Glads								ber or Rur enue	al Route Nur Chur	onber, City or chton,	Town, State Mary	land 20733
or Heal	20b. Place of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: Our Lady							netery,	I	Date	20c. Locati	on - City or	Town, State
ti Page trment trant:								urch (Rive	r, Maryland			
Balt permit Depart Impor injury	4 Donation 5 Other Specify: Our Lady of Sorrows Church 07/14/2010 West R: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Fu 2973 Solomons Island Road, Edgewa												
Physician	Ť	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										r heart	Approximate Interval Between Onset and
/M i l Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Alcol	nol and		hado	ne Into	xicat	ion				Death
	١	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
	Examine	cause. Enter Underlying Cause (Disease of injury that initiated	c										
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876(tificate ng phy	Ž	IF FEMALE: 23b. Was decedent pregnant in the		outcome of pre birth		Fetal	death 3	Ectopic	pregnanc	y	23d. Dat Mont	e of deliver	y Day Yea r
Box 68760, e death certificate be the attending physic of for use as the bur	Physicia	past 12 months? 1 Yes 2 No 9 Uni	4 Preg	nant at time of			r (Specify)						,
b. BC the dea	ᇍ	Part II. Other significant condit	9 Onkn		resulting	in the und	ferlying cause gir	ven in Par	† 1	23e. Did to	obacco use o	ontribute to	the cause of death?
P.C es that iigned be deta		Chronic Alcoh	_				,			1 Yes	2 No	3 Pro	babiy 4 🗹 Unknown
ords, w requir	Completed by									24a. Was			utopsy findings available completion of cause of
Reco	dwo										rmed?	death?	
Vital Rec ysician: The his certificate	Bec	25. Was case referred to medica examiner?					26.Place						
of Vid	의	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2		patient :		Other ₄			Residence		r. Scene
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly.											mber or Ru	ural Route Number, City	
Dj ospital hours a meral J													
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one) 2 Medical Exa	miner: On the basis and manner:	of examination	-		n, in my opinion,	death occ			and place, ar	nd due to th	ne cause(s)
	Σ	29b. Signature and title of certifie	er				29c. License					- ,	nth, Day, Year)
K41		Family 9	rushall 1	M	22-1		O.C.N	n. ⊏.			July 9, 2	.010	
`		 Name and address of person Pamela E. Southall, N 		se of death (Ite Medical Ex	,	111	Penn Street,	Baltimo	ore, MD	21201			
Sta		31. Date filed (Month, Day, Year)	2010 32. R	egistrar's Signa	ature	1							
Registi	rar	JUL 1	4 ZUIU /	enera	A.	Sar	Kal						

10-04969 Robert North Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 22101 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month D July 2, 2010 North 1600 hrs **Medical Examiner** Robert 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Anne Arundel 927 Main Street 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6 Sev **Funeral** 220-70-1711 Director 12/09/1954 country) Maryland 1XM 2F 55 Usual Residence of Decedent 10d. Inside City Limits ıny 10a. State 10b. County 10c. City. Town or Location Anne Arundel Deale Marvland 23a or 28a-f show notified at once. 1 Yes 2 X No death with the Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 927 Main Street 20751 Funeral 11. Marital Status 12, Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after neart of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", o or other traumatic event, the Medical Examiner. Specify: White 3 Widowed 4 X Divorced 1 Yes 2 X No specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Giant Food Baltimore, MD 21215-0036 Construction Co. Carpenter 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Robert R. North Martha Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 715 210th Street, Pasadena, MD 21122 Robert R. North - Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 7/7/2010 Baltimore, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Atheroscleotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED, 27, X UNPENDED attending physician or use as the burial per ME G905 7/22/10 TT Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed certificate Yes 2 No 1 🗸 Yes 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA Inpatient 2 After this 1 Yes 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Director; 5 Pending 1 Yes 2 No hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) within 24 hours a To the Funeral determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E July 3, 2010 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD Assistant Medical Examiner 31. Date filed JULh, 0,92010 State Registrar's Signature ark Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 3:00 p M Mark Scott Newel1 July Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 50395 Beach Drive St. Mary's Scotland Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 | F Months Days Hours (Month, Day, Year) 10/28/1961 Director 48 Wisconsin 390-48-4734 Usual Residence of Decedent 10a. State 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 🗌 Yes 2 🔀 No Maryland St. Mary's Scotland 10e. Street and Number r items 23a or ner must be n 'n 10f. Zip Code 10g. Citizen of What Country? Funeral 50395 Beach Drive 20687 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc. hours after ò ð 1 Never Married 2 Married X Yes 2 No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural" 3 Widowed 4 Divorced Specify. Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Defense Contractor 6 Business Manager Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever 2 Judith Burke Roy 0. Newell Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Roseanne M. Newell/Spouse 50395 Beach Drive, Scotland, MD 20687 other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 07/10/2010 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 No sate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No To the Hospital or Attending Physician; I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/ar investigation. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) 0055751 July 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ema Jennifer Schmidt, D.O. 40900 Merchants La., Leonardtown, MD 20650 31. Date filed (Month, Day, Year) Registrar's Signature 32. State 07 Registrar

		1	For State		Stat	e of Ma	ryland		rtment of F tificate of t		d Men		giene Reg. N	010)	221	03
			Registrar 1. Decedent's Nam	ne (First, Middle	e, Last)							Date of Dea		Yea	25	3. Time of I	Death
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17. Father's Name (First, Middle, Last) Adolphus O'Brien 18. Mother's Name (First											,						
should and Miss	PAGOIPRUS O'Brien AGOIPRUS O'Brien 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route It										oute Numb	er, City or	Town, Stat	e, Zip (Code)		
and 2			Hazel R.	. O'Bri	en/wife			L	Bittinge			ton,		21561			
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State of Maryland / Department of Health and Mental Hygiene 2010 22104

		1	State Registrar		Cer	tificate of	Death			Reg. No.					
	-: · ·	,	1. Decedent's Name (First, Middle, Last,)	2. Date of Death Month Day Year										
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	Funeral Director		5. Social Security Number 6. Security Number 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5 1	7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days			8. Date of Birt Feb. 10	9. Birthplace (State or Foreign Country) Towa					
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	e Mar 7 28a notifi	je	Maryland Prince 0	George's		10f. Zip Code	alls	ville		10g, Citizen of What Country?					
	with the 23a or sst be	Funeral Director	2400 Queens Chap	el Road		Tor. Zip code	20982	2		United States					
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036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 2be notified at ic event, the Medical Examiner must be notified at	þ	1 🏝 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		1 ☐ Yes 2 🖾 No Specify:					Black, Whit pecify: B1	ack			
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	□ □ = a o	Ш	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
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ز	/Medic Examin		4a. Facility Name (If not institution, g			TAL		Town, or	Location of	f Death		4c.	County of Deat	n
ž	Funeral Director				X 7. Age (In yrs. last birthday) 67 Yrs.			If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. 12-28					9. Birtl	nplace (State or Foreign untry)
	show	or	Usual Residence of Decedent	GEORGES		y, Town or I	_ocation							10d. Inside City Limits 1 XYes 2 □ No
	with the N Is or 28a-1	i Director	10e. Street and Number 10105 BALSAMWOOI		LAC			Code				10g. Citiz	zen of What Co	untry?
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	and 2 sh elth and 127 ie m er traum		19a. Informant's Name/Relationship COMFORT OWOLABI/								AUREL,		Town, State, 2 20708	lip Code)
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8760,	death certificate be executed Medical	icai Examiner	23a. Part1. Enter the disease, or so shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) 55. Landelly 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	mplications that cause by one cause on each live one cause on each live one cause on each live one cause on each live one to (or as but one to (or as c.) Due to (or as d.)	SCLE: a consequence	ROTIC (uence of):						rrest,		Approximate Interval Between Onset and Death
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Division of Vital Records,	: The law recele hes be-	Completed	THROMBOCYTOPENI	A							24a. Was autop perfo 1 Yes		24b. Were au prior to death?	topsy findings available completion of cause of 2 No
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Divis	itai or Atters efter de rs efter de l'Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, el	c. (Specif	(y)					City or Tov	vn, State)		iral Route Number,
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2	3		30. me and address of poon wh	•		, , , , ,		1.7 A CT	ITNIOTO	ON T). 	17		
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20-1

State Registrar MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jullivan

MO

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 4a per DVR G905 / L7/Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010^{Year} Physician/ July 5 3:10A M Petersheim Annie D. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 404 444 Pleasant Valley Road Oakland Garrett 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral 1 🗆 M 2 🔀 F Months Days Hours Min 6 197 1911 Virginia 99 Yrs. Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10d. Inside City Limits 1 🗌 Yes 2 😾 No Garrett Oakland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 404 Pleasant Valley Road 21550 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any Injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home 6 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Noah C. Beachy Katie Schrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pleasant Valley RD., Oakland, MD 21550 <u> Fred Petersheim/ Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) abaugh Cemetery 7/7/2010 Oakland, Maryland 21. Signature of Funeral Service 22. Name and Address of FacilityNewman Funeral Homes P.A. Malte Second St., Oakland, MD 203 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequenty of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Due to lor as a considuence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 10 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 Yes 2 L 1 Yes Be (Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) 8 D42464 address of person who completed cause of death (Item 23a) (Type, Print) Sotière Savoppulos MD 255 North Fourth St., Oakland, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 Fleming Porter 24 11:45 AM June Medical 4a. Facility Name (if not institution, give street and number) Examiner Center 4b. City, Town, or Location of Death 4c. County of Death FT Washington Health/Rehabilitation Fort Washington Prince George's if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April / 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 A M 2 □ F **Funeral** Months Hours Georgia 86 1924 Director 255-22-5179 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Clinton Marvland Prince George's 10e. Street and Number 10g, Citizen of What Country? Funeral 5907 Darlene Drive 20735 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc.

Specify: African
American Armed Forces by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 3rd College (1-4 or 5+) Refuse Removal Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental H item 27 is marked of ည Lucy Johnson Fleming Porter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7840 King Arthur Court White Plains, Md. permit. Page 1 and 2.
Department of Health
Important: If item 27
any injury or other tr
once. Verniece L. Rorie/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 30, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Clinton, Maryland Resurrection 21. Signature/of Furieral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. Mnn 20019 4001 Benning Road NE Washington, DC Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List only one cause on each line. 23a. Part . Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Terminal Postrate Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ for in the past 12 months? Day Month Year Pregnant at time of death 2 No the g 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det \$ 2 ♣No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Was an autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be □ Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, the Hospital or Attending Physician;

5

State Registrar (Check only one)

3 🗌

29b. Signaty re and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D24535

29d. Date signed (Month, Day, Year,

June 29, 2010

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Amend#7 per FD 6/30/210 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AA Co. Health Dept lo State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE 25^{Day} 2010 Catherine Virginia Rankin 1:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death Worchester Berlin Nursing Home Berlin 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 19<u>16</u> 1 M 2 TF Months Days Hours Min. April 14 Virginia Director 226-10-6385 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Worchester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 103 Boston Drive 21811 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 2 XNo 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) alth and Mental Hygiene. 27 is marked other than Book Keeper Peoples Drug Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Grace Landis J.J. Jarrels 19a. Informant's Name/Relationship (Type, Print) CATHERINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Greenan/ Niece Important: If item 27 any injury or other the once. 103 Boston Drive Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₽ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 6/30/2010 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causing each line. Approximate Interval Between Spiset and Death Immediate Cause (Final Physician neumonia disease or condition gavs Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of imjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 Xo Congestive 2 🗌 No 1 🗌 Yes 25. Was ca referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 8 B 26. Place of Death (Check only one) Hospital: 1 Tes 2 X No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) н 0070020 June 25, 2010 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Diane Ceruzzi, D.O. 9715 Healthway Dr, Berlin, MD 21811

Registrar

DHMH 17 Rev 7/2009

Year)

JUN 2 8 2010

32. R gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month VICLI AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 2106 Bromley Court Crofton 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Months 09/19/1923 Pennsylvania **Director** 86 190-14-1450 Usual Residence of Decedent should be filed within 72 hours and the and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show the marked other than "addical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Crofton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 2106 Bromley Court 21114 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) United States Colonel Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Louis Reynolds Mittie Tague 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106 Bromley Court, Crofton, Maryland 21114 permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Patricia Reynolds Miles/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or oth Arlington National Cemetery 09/20/2010 | Arlington, Virginia 4 Donation 5 Other (Specify) 21. Signature of Fur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art 1. En shock, o heart failu Immediate Cause (Final heart failure. List only one cause on each line Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an the Hospital or Attending Physician: The law has e 2 s certificate has lirector, page 2 autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner' 1 Tes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury 28b Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of ce

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State Registrar

2 31. Date filed (Month, JUN 2 5 2010

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nwho complete ause of death (Item 23a) (Type, Print) ENDAMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. 22 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July 2010 A^M 1:45 Frances Maxine Rogers Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Garrett Oakland Nursing & Rehab. 0akland Center 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 6. Sex Date of D. ... (Month, Day,) WV Country) Days Hours Min 1 M 2 X F Dec. Director 234-22-6298 86 Usual Residence of Decedent 28a-f shov 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho "natural", or items 23a or 28a-f sho 10a. State Director 1 ¥ Yes 2 ☐ No MD 0akland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 United States 706 E. Alder Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. , or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Shively Inez Ramsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia R. Varone, Daughter 1510 S. W. 110 Way, Davie, Florida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or of 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) East Oak Grove Cemetery 7/7/2010 Morgantown, WV 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 Signature of Funeral Service Licensee Katherine Du 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Antaroscharoti c disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate begathours after death.
• Funeral Director: After this certificate has been signed by the attending physicial. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 X No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably should k 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 Yes 2 No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 📉 o funeral director, 26. Place of Death (Check only one) Be 2 No Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 5 Pending 2 🗌 No ☐ Accident Investigation filled in by the 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 3 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

Gald

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

² 7 2010

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
JUL 0 1 2010

OPHNELL ALFRED CUMBERBATCH M.D. 8416 CENTRAL AVENUE LANDOVER, MARYLAND 20785

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 2010 Year CARRIE SHERMAN JUN 7:09 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Hours Min. Country) Yrs **Director** JUN 10 2010 MD Usual Residence of Decedent or 28a-f shov 10b. County filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 202 SOMERSET BAY DRIVE APT 301 21061 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. BLACK 3 Widowed 4 Divorced Specify. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve anose. ပ JAEWLAYE KIAH SHERMAN OLIVIA L. BARBUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 OLIVIA BARBUE MOTHER 202 SOMERSET BAY DRIVE 301 GLEN BURNIE MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1

Burial 2

Cremation 3

Removal from State 4 Manual Specify) 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facili Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician EXTREME PREMATURITY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Day Year 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 🗌 No 1 Yes Yes 2 12 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 뎯 Other: 2 X No 1 🔼 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 11,2010 01066987A (IN) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER KATRINA VONGSY USN LT BETHESDA MD 20889-5600 31. Date filed (Month 32. Rigistrar's Signature State ack Registra

For AMEND#28a, b, c, d, e, fState of Maryland / Department of Health and Mental Hygiene 2010 State Per PHY. 6/29/2010 AACO HEALIH CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edna Sweeney Day R. June 201^{vea} 25, 8:15 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Anne Arundel Harwood 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Hours Min June 17, Year 1939 Maryland Director 215-36-4743 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Prince George's MD Bowie ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a o 7 must b Funeral 3800 Enfield Chase Ct. Apt. 110 20716 USA items . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter idical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Specify: White Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) P.G. County Board Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Cook of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ be f of Health and Ment fitem 27 is marked rother traumatic e Lingan Anderson Kathleen Zuras should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Walter Cleveland Sweeney Jr./Son 102 Tennesse Road, Stevensville, MD 21666 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 0 Important: If any injury or 4 Donation 5 Other (Specify) Marvland Veterans Cemi 6/30/2010 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home <u>6512 NW Crain Hwy., Bowie, MD 20715</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 10 YRS Medical Due to (or as a consequence of): Examine Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and defached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Other (specify) Month Day Year Yes 1 ☐ Yes 2 ® 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending Accident
Suicide Investigation 1 Yes after death 6 Could not be 28e. Place of Injury - At hor building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERARDOM 6510 KENILWATH SU #2700 31. Date filed (Month, Day, Year) State 32. Raistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 | 0 22 | 5 State of Maryland / Department of Health and Mental Hygiene

yson Michaei	3110	1- For State Certificate C			a Na						
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death					
edical Exami	ner	Jayson Michael Shooks		July 4, 201	0 ′	1917 hrs					
		Facility Name (if not institution, give street and number) St. Mary's Hospital	4b. City, Town, or Location of Deat Saint Mary's	th	4c. County of Death St. Mary's						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hi	rs. 8. Date of Birth	h(MM/DD/YYYY) 9. Birl	hplace (State or					
Director			rs. Months Days Hours Mi	n April	26,1989 Foreig	n _{untry)} Mary land					
á		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits					
Maryiand 28a-f show any <u>d at once.</u>	Į.	Maryland St. Mary's Mechanic	csville			1 Yes 2 X No					
farylau 28a-f s Lat on	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?					
vith the Maryland s 23a or 28a-f show e notified at once.	ij	27166 Neale Court	20659	U	United States						
ith wit tems 2	Funeral	1 X Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin?(5 Yes, specify Cuban, Mexican, Puert	Specify Yes or No- to Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,					
her dea	/ Fu	1 Yes 2 No No Specify: Specify: Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Willowed Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Willowed Wildowed Wildows No. 1 Yes 2 X No. Specify: Willowed Wildows No. 1 Yes 2 X No. 1 Yes									
ours af atural xamin	d by	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indu									
36 in 72 h ran "n ical E	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Installer Floor									
d with	om	17. Father's Name (First, Middle, Last)	aiden Surname)	8							
215 be file ntal Hj rked o ent, th	Be C	Robert C. Shooks	Rita A	. Dinora							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	7		ing Address (Street and Number or 6 Neale Court, Me								
and 2 lealth 2 tem 27 traum				July 10,	20c. Location - City or						
10re ages 1 nt of H t: If i		1 Burial 2 Cremation 3 Removal from State crematory or o	other place) 1d-Echols Crem.	2010	Charlotte	Hall, MD					
altin mit. P oartme portan			Name and Address of Facility Br								
ii T C P			0195 Three Notch								
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death					
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Death					
		Sequentially list conditions, b.									
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	cal E	d. UNPENDED AMENDED		<u>-</u>							
60, ate be e hysicia e buria	Vedi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery						
Box 6876 death certificat he attending ph.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregr	nancy	Month D	yay Year					
Box e death of the atter	ysic	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)								
O. I hat the etache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to						
S, P.C uires that n signed Id be detz					2 No 3 Prob						
of Vital Records, P. Ig Physician: The law requires the uner this certificate has been signed meral director, page 2 should be de	ompleted			24a. Was ar autops perform	y prior to c	topsy findings available ompletion of cause of					
tal Rec cian: The l certificate bector, page	Con			1 ✓ Yes 2		s 2 No					
fital F sician: is certifi lirector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient	26.Place of Death (Check		Residence 6 Other						
of V ing Phy After th uneral d	. To	27. Manner of Death 28a Date of Injury 28b Time of		28d. Describe ho	ow injury occurred						
ion tendin leath. tor: A	atior	1 Natural 5 Pending FOUND: POUND: 2 Accident Investigation Jul 4, 2010 1807 hrs	1 Yes 2 ✓ No	Subject hang	jed self						
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	or Town, Sta	treet and Number or Ru ate)						
To the Hospital within 24 hours To the Funeral		4 Homicide 29a, Certifier Control Physician To the based of the second	urrad at the time, date and place as		ourt, Mechanicsville,						
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Yes the state of the control of the cause											
To To	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	nth, Day, Year)					
		W Co	O.C.M.E.		July 5, 2010						
me		30. Name and address of person who completed cause of death (Item 23a)	1 Penn Street, Baltimore, N	MD 21201							
	ate	31 Date filed (Month, Day Year) 32. Registrar's Signature									
Regist	e Kê	UII 0 9 2010 A A	arked	OGM	lE						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 29 2010 14:11 PM Manuel Stanley III June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Union Hospital of Cecil County Cecil E1kton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country 1 kton Mary Land 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F **Director** 213-84-3899 Oct. 4,1954 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1XX es 2 □ No Maryland Cecil Perryville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21903 Funeral 418 Otsego Street United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2XXMarried 2 X No permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event. The Mental Experiment Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. 9 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 <u>Paver</u> Road Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuel Stanley Jr. Thelma Biddle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freda Stanley / Spouse 802 Elk River Manor Drive, North East, Maryland21901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East Methodist July 2,2010
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East, Maryland 21. Signature of Pure Moervice Live 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** ardroc unknown arres disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** rere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner se to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 **N**o 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral to Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person completed cause of death (Item 23a) (Type, Print) Elltonimo 2000 Cotso moin 32. Registrar's Signature 31. Date filed (Month, Day, State 0 2 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3. Time of Death Year Charles Joseph Savage /Medical June 27, 2010 10:25 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2504 Gillis Road Airy Year If Under 24 Hrs. Mount Carroll 525 Special Security Number 218-36-3276 **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F Days Director Hours Min Yrs 93 18, 1916 Maryland Usual Residence of Decedent 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hyglene.

ant: if item 27 is marked other than "natural", or items 23a or 28a-f shov lurv or other traumatic event, the Medical Evanther must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll 1 ☐ Yes 2 X No Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2504 Gillis Road Funeral 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black, White, etc. ò 1 ☐Yes 2XNo 3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates Specify. Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 self-employed farmer agriculture 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ျ Harry Randolph Savage Osie Bertha Poole 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald S. Savage, son 2504 Gillis Road, Mount Airy, <u>Maryland</u> 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If it any injury or conce. Date 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) Monocacy Cemetery 7/2/2010 Beallsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMolesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical WEEKS Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending pr IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? s been signed by the should be detached □Yes 2□No 5 ☐ Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 😿 No 3 Probably 4 Unknown r this certificate has trail director, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ٩ 1 Yes 2 No Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation filled in by the 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10102 June 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Rochelle Dyer, CRNP,

31. Date filed (Month, Day

32. Registrar's Signature

1502 South Main Street, Suite 104, Mount Airy, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,7,8 per inf g906 8-11-10 vt State of Maryland / Department of Health and Mental Hygien (2) | () State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IRENE SMITH - HENDERSON E JUNE 2010 8:20 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1844 RYDER WOOD COURT HYATTSVILLE PRINCE GEORGES 7 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 938 g. Birthplace (State or Foreign **Funeral** 1 □ M 2 **X** F Months Days Hours Min. RICHMOND, VA Director Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGES HYATTSVILLE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1844 RYDER WOOD COURT 20785 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK "natural", 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE TEACHER 3YRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P .. Page 1 and 2 should be treent of Health and Mente tant; If item 27 is marked jury or other traumatic e UNKNOWN CASSIE SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTONIO SMITH/ SON 1844 RYDER WOOD COURT, HYATTSVILLE, MD 20785 Baltimore, 20a. Method of Disposition
1 ₹ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o WASHINGTON NAT'L CEM JULY 9,2010 SUITLAND, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD., LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ENDOMETRIAL CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 🕅 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify Hospital: 2 🔀 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending n 24 hours after death.

le Funeral Director: A oleted filled in by the fu death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JUL 0 1 2010 State Registrar

8824 CUNNINGHAM DR. SUITE E, BERWYN HEIGHTS, MD 20740 DR. KEVIN SCOTT, MD 32. Registra 's Signa ure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00038534

29d. Date signed (Month, Day, Year) JUNE 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 330 AM Sin 1AMES UN 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cherry Hill Nursing Home Laurel Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 X M 2 □ F 68 April 12, 1942 West Virginia 235-66-7628 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 922 9th Street NE 20002 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Specify: African 1 Yes 2 No Specify: 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Lawson Charles Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15104 McKnew Road Burtonsville, Md. Crystal Proctor/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Blue Ridge Date e 30, 20a. Method of Disposition 20c. Location - City or Town, State June 1 Burial 2 □ Cremation 3 □ Removal from State Beckley, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2010 Memorial Gärdens 21. Si ture of Funeral Service I 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC 3-4 WEEKS Due to (or as a consequence of): COMPRESSION SPINA CORN Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes performe 2**X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3□ D0A 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending

Physician /Medical Examiner Examiner requires that the death certificate be executed and

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or edical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical

Maryland 21215-0036

Baltimore,

Box 68760

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Division o	To the Hospital or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral
OR_	4

State Registrar

Medical

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of

	and manner stated.							
f certifier	ATTEXDIN !							

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

0005 7216

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my online, death postured at the time date and place.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DAD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

READICE M. N. 3450 FORT MEADE

investigation 6 Could not be determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22120 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ Hazel Veronica Smith 2010 5:10 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.

Market Navs Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Washington, DC Director 579-12-6863 90 1920 Mav Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Prince George's MD Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1400 Legation Road 20782 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify 3 ☒ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter J. Reck, Sr. Evangeline F. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is 1401 Legation Road, Hyattsville, MD 20782 Crystal L. Floyd / Friend 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 7/3/10 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 For Loyns Gasch's Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a connce of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 X No 9 Unknown Part II. Other significant conditions contrib et-resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🕱 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred X Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours af Funeral Di Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only dr 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912 Nasreen M. Kango, 7701 Carroll Avenue, Takoma Park, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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П	Funeral		5. Social Security Number 6	. Sex 1 □ M 2 🗓 F	7. Age (In yrs. I	Ven	Months Days	Hours	Min.	8. Data of Birt (Month, Da		Cor	untry)
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	r 28a	Director	10e. Street and Number				10f. Zip Code				10g. Citize	en of What Cou	untry?
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lar	and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. A Zi is marked other than "natural", or items 23a or 28a-f show ner fraumatic event, its Medical Examinar must be notified at		19a. Informant's Name/Relationsh										
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it a fraction Evantant must be notified at once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		St.	Mark U	AME Cemeter 2. Name and Addre						al Home, P.A.
Ba	permi Depar impo any Ir		Kenne to	Philo.					P.O.	Box 270	Leonar	rdtown,	MD 20650
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	deat he att ed for	sicis	in the past 12 months? 1 □ Yes 2 ►No	4 □ Pro 9 □ Un	egnant at tima of known	daath 5	Othar (specify)						
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical one)	Examiner: On th	e basis of exami anner stated.	nation and/or	investigation, in my	opinion, de	eath occu	irred at the tim	ie, date and	u piace, and u	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Raymond Thomas 30° 2010 7:00 Рм Medical 4b. City, Town, or Location of Death Columbia 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 7261 Eden Brook Drive Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 212-36-5848 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex. 1 🖾 M 2 □ F Funeral Months Days Hours (Month, Day, Year) **Director** 8/10/1936 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director Howard Columbia 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 7261 Eden Brook Drive 21046 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 △ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 1955–58 3 Widowed 4 Divorced Specify: White Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hyglene. tant. If item 27 is marked other than "natur ury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pastor United Methodist Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Raymond Thomas Leila Elizabeth Seitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therese M. Thomas - Wife 7261 Eden Brook Drive Columbia, MD 21046 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it injury o 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 7/1/10 Hanover, MD 21. Signisture of Funeral Service Licensee any inj once. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Multiple Physician Myeloma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by bong Fractures 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed death? Yes 2 ☐ No Yes 2 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospnan within 24 hours after death.

To the Funeral Director. After this certifica

(Check

only one) 29b. Signat

3 Certifying Nurse

YYD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

re and title of certifie

Registrar DHMH 17 Rev 7/2009

State

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D30573

10710 Charter Drive Suite 6000

29d. Date signed (Month, Day, Year)

7-1-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 10 22123

			1 - For Stata Registrar	State of Marylan		tificate of			Reg. No		22123	
			Decedent's Name (First, Middle, La	ist)				2. Date of De Month			3. Time of Death	
^	Physicia /Medic		WILHELMINA	TILLMAN	I			JUNE	23	2010	8:32 A M	
4	Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, or CHEVE	r Location of Death		1	:. County of Deat PRINCE G		
-			PRINCE GEORGE 5. Social Security Number 6.	Sex 7. Age (In yrs. i	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da			nplace (State or Foreign untry)	
	Funeral Director		249-36-5532	1□M 2 F 78	Yrs.	Months Days	Hours Min.	MAY 16	y, Year) 19	32 SOU	TH CAROLINA	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								10d. Inside City Limits	
	Maryl -fehc	tor	MD PRINCE	GEORGE'S BC	WIE						1 X Yes 2 □ No	
	or 28a	lrec	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What Co	untry?	
	23a	Funeral Director	11401 WENDY HARB	T			20720			SA		
	er de	une	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 X No	S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, White	e, etc.	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heelth and Mental Hygiene. Item 27 Is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, Ita Medical Evantral must be notified at	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify: BI	ACK	
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7	e filed within al Hygiene. I other than "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired CLERK	d)			GOVERNMENT		
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and	lid be hental rked c	To Be	LOUIS BROWN SR.				MARY S	SINGLETO	ON			
ary	2 should and Men Ie marke raumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Numb	er, City	y or Town, State, Zip Code)		
	and 2 eelth m 27 her tr		MARSHA ZACKER			WENDY H	ARBOR WAY	BOWIE,		YLAND 2 ocation - City or	20720	
2	iges 1 nt of H i. if ite or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3	Removal from State	emetery, crer	natory or other place JET CEMET	ce)	2010		SHINGTON		
Dallillo	permit. Pages Department of H Important: If its any Injury or of		4 □Donation 5 □Other (Spec	77		2. Name and Addre				S FUNERA		
n D	Depa Impo any I		(/k			7474 LAN	DOVER ROA					
Ī			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	pplications that caused the death	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition	CORONARY A	RTERY	DISEASE					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence CONGESTIVE		r fatilire						
-		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence								
	cuted	Examiner	that initiated events	RENAL FAII	LURE							
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XOC	reartific nding p use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date of de	livery	
	the death cer y the attendin iched for use	Physician/N	in the past 12 months? 1 — Yes 2 TNo	1 Live birth 2 Fete 4 Pregnant at time of d 9 Unknown		Ectopic pregnancy Other (specify)	/			Month	Day Year	
г Э	at the	Phys	9 □ Unknown		41 - 1 - 44 -	- 1 - 1 - 5		220 Did	lobasso	. uso contributo t	the cause of death?	
as,	w requires that the death certif been signed by the attending should be detached tor use as	ρ	Part II. Other significant conditions SEIZURE DISORDE	_	uiting in the u	nderlying cause giv	en in Parti.		Yes 2		robably 47 Unknown	
coras	w requ	lete						24a. Was	an		utopsy findings available	
Ē	Physician: The law this certificate has t ral director, page 2 s	Completed						auto	psy ormed?	prior to death?	completion of cause of	
<u> </u>		Be C	25. Was case referred to medical examiner?				26. Place of Dea		-			
5	Physician: r this certitic ral director,	မ	1 ☐ Yes 2 💢 No		ER/Outpatier		4 Nulsing II			6 □Other (Spe	cify)	
	ding After funer	tlon:	27. Manner of Death 1 XNaturat 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	yat rk? Yes 2 □ No	28d. Describe	now inj	ury occurred		
DIVISION	il or Attending elter death. I Director: After d in by the fune	Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be One Blace of toiner At he	ome, farm, str			28f. Location (ural Route Number,	
5	rs etter rel Dir	Cert	Thomas .	Building, etc. (Specif	,, 				,, Ola			
286. Date of Injury - At home, farm, street, factory, office 287. Location (Street and Number or Ric City or Town, State) 288. Place of Injury - At home, farm, street, factory, office 289. Certifier (Check only one) 290. Certifier (Check only one) 291. Certifier (Check only one) 292. License number 293. Date signed (Mont								s stated. e to the cause(s)				
	ro the vithin of the complex	Me	29b. Signature and title of certifier	//	7	29c. Licens	se number		29d. D	ate signed (Mon	th, Day, Year)	
	0		> XX	mm		D162	273			6/2	4/10	
	4		30. Name and address of person who REVATHY MURPHY	completed cause of death (Item M.D. 6130 LAN			ERLY, MAR	YLAND	2078	35		
Í	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 1 2010	32. Registrar's Signa					-			
	negisti	all	JOIL V - LUID	menda h. W								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RIVA DIOOPM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death RUNDEL 8. Date of Birth (Month, Day, Year) May 26,1920 Social Security Number If Under 1 Year If Under 24 Hrs. Funeral Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. 1 M 2 F Months Days Hours Pennsylvania 90 172-18-9416 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21061 8028 Merrychase Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Merchant Music 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matteo Passalacqua Rose Corso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lee Barto / Daughter 8028 Merrychase Court Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 28 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) McMurray, PA Queen of Heaven Cemetery 2010 21. Signature of Fur. of Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final Physician/ 605 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 No ed by the a 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been signated by page 2 should b Completed 1 Yes 2 🗹 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 No Other: မ VIN 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral or Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 4 Natural 5 Pending 1 Tyes Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date fled (Month, Day, Year) JUN 2 5 2010

graddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. N2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Thomas Virgil Winzenwrith 12:00 P M <u>June</u> 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Arundel **Examiner** Glen Burnie 190 Virginia Lane, Apt. B 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 58 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth i. Social Security Number 220-56-2067 **Funeral** Days (Month, Day, Year) 10/31/1951 1 🗓 M 2 🗆 F Months Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director Anne Arundel Deale Maryland 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 20751 Funeral 5868 Swamp Circle Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify. If Yes, Give "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7'. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event. The Meany injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Private Laborer Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Geneva Mae Thomas Virgil Bernard Winzenwrith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 190 Virginia Ln. Apt B, Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type, Print) Roseanna Phaneuf - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 7/2/2010 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Signature of Funeral Service Licenses 147 Duke of Gloucester St, Annapolis, MD 21401 Muzlin . Klot 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Respiratory Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Kidney Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami Liver Cancer or Attending Physician; The law requires that the death certificate be executed and -trans Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Month Pregnant at time of death Yes 2 No been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cancer of esophagus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s auto, performe 2 🗌 No this certificate 1 Yes 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 515 Hospital Other: home 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 IDOA ည 4 Nursing Home 5 Residence Other (Specify, Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work?
1 Yes 2 No ☐ Natural ☐ Accident 5 Pending Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year 6/28/2010 29b. Signature and title of certifier 29c. License number D29748 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Alit Manejwala 1
31. Date filed (Month) 11 N°2 9 2010

1307 Crain Highway SE

32. R gistrar's Signature

21061

Glen Burnie, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KUESDALE 700 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Anne Arundel Harwood Mandarin House Hospice 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🔀 (Month, Day, Year) 954 South Carolina Months Days Hours Min. 248-04-7816 56 June Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State at within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No Temple Hills Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20748 United States 5002 Wilkins Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by **Black** Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 → Widowed 4 □ Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur lury or other traumatic event, the Medical lury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene Mack Roy E. Truesdale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5002 Wilkins Drive Temple Hills, Md. 20748 19a. Informant's Name/Relationship (Type, Print) Carmen Ware/ Daughter Baltimore, 20a. Method of Disposition July Date 3, 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a Department of h Important: If ite cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 2010 Suitland, Maryland injury 4 Donation 5 Other (Specify) Washington National 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Furreyal Servi 20019 4001 Benning Road NE Washington, DC Approximate Interval Between Onset and Death 23a. Party Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, REAST Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami • Hospital or Attending Physician: The law *equires that the death certificate be executed 24 hours after death.
• Experient Director: After this certificate has the signed by the attending physician and leted filled in by the furneral director, pige 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 5 Other (specify) 1 Yes 2 ve 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 Minknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s has t performed 2 autopsy 2 🗆 No 1 🗌 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) æ Other: 2 1000 4 Nursing Home 5 Residence 6 Wother (Spe ည 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of HOUSE 28c. Injury at 28d. Describe how injury occurred Certificate: ivianner of De Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signatur and title of certifie 29d. Date signed (Month,

Registrar

State

		-	For State Registrar	State of Ma	aryland		rtment of H tificate of D		Mental Hyg	giene Beg No 2	010	221	27
			Decedent's Name (First, Middle, La	ast)					2. Date of Dea	ath		3. Time of De	
	Physicia Medic		Donna M.	•	Yager		_		July	l,	2010	8:52 p	М
	Examin		4a. Facility Name (if not institution, giv				4b. City, Town, or		ath	4c. County of Death			
مر	<u> </u>		40651 Clearfie				Leona	rdtown If Under 24 Hr		St. Mary's			
	Funeral Director			Sex 7. Age 1 ☐ M 2 🛣 F	e (In yrs. las 56	t birthday) Yrs.	Months Days	Hours Mir		n , Year) 1953	9. Birth Coul	place (State or F ntry) Ohio	
			Usual Residence of Decedent						105/21/				
	yland f sho ed at	ito	10a. State 10b. County	Manus I a		Town or Loc conard						10d. Inside City	
	e Mar r 28a- notifi	Öire	Maryland St. N	Mary's	Le	onard	10f. Zip Code		1	10a Citizo	n of What Cou		ALI NO
	ith th	Funeral Director	40651 Clearfiel	lda Court			2065	in		rog, Onize	U S A	ilu y :	
	ems sems	nue	11. Marital Status	12. Was Decedent 8	ever in U.S.	13. W	as Decedent of Hi	spanic Origin? (Specify Yes or No-	14.	Race - Ameri		
ထွ	ter de , or it	by	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔀 1f Yes, Give	No	i	Yes, specify Cubar ☐ Yes 2 🖾 No		rto Rican, etc.)	l en	Black, White,		
g	ours al tural" al Exa	Completed	3 Widowed 4 Divorced	Year or Dates.	Year or Dates.						Specify: White		
5	72 hc n "na Medic	nple	15. Decedent's (Specify only highest of	grade completed)		(Give k	ent's Usual Occupa ind of work done d O NOT use retired)		orking	16b. Kina	of Business Ir	ndustry	
212	within giene. er tha the I	S	Elementary/Seconday (0-12)	College (1-4 or 5	p+)		nancial	Analyst		Gover	nment	Contrac	tor
ם	filed all Hyg		17. Father's Name (First, Middle, Last	9					ame (First, Middle,		-		
<u> a</u>	Ment Ment narke	욘	Frank Kuenze					Lou		enders			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship Charles Yager/S										
<u>ရ</u>	and Healt tem 2		20a. Method of Disposition	pouse	20b. Pla	ace of Dispos	sition (Name of		Date		tion - City or T		\neg
ص ا	age 1 ent of nt: If i		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			•	atory or other place $1\mathtt{d-Echol}$		/05/2010	Char	lotte	Hall. M	D
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once.	. 3	21. Signature Funeral Surprise		1	22	Name and Addres	s of Facility	Brinsfiel	d Fun-	eral Ho	ome, P.A	
<u>m</u>		6 17		field, Jr.		032			Rd., Leo		own, MI	20650	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that caused one cause on each line	d the death. e.	Do not ente	r the mode of dying	g, such as cardi	ac or respiratory an	rest,	1	Approximate Interval Betwee Onset and De	een
	Physician/ → Medical	8 11	Immediate Cause (Final disease or condition resulting in death)	a. META	STAT	CL	UNG	CARCIL	VOMH			3 MON	
	Examiner		Toolating in doctory	Due to for as a consequence of).									
		ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a conseque	ence of):							
	uted	Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events c.				_						
	cate be executed physician and s the burial-transit	a E	resulting in death) Last	Due to (or as	a conseque	ence of):					-		
90	ate be physic the bi	edical		d		_							
687	eath certifica attending p	Ž/U	IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, outcome						23	d. Date of deli	very	
ŏ	eath c atter	icia	in the past 12 months? 1 ☐ Yes 2 🔀 No	4 Pregnant a			Ectopic pregnand Other (specify)	У			Month	Day Ye	ar
E	requires that the de been signed by the should be detached	Physician/M	9 🗌 Unknown	9 Unknown									-41.0
<u>. </u>	ss that igned be de	ğ	Part II. Other significant conditions	contributing to death t	out not resu	iting in the u	nderlying cause giv	en in Part I.				the cause of dea obably 4 🗌 Ui	
rgs	equire	Completed		-					24a. Was			opsy findings av	
ပ္ပ	The law cate has the page 2 s	dm							autor perfo	psy ormed?	prior to c death?	ompletion of cal	
Ž	sician: The certificate rector, pag		25. Was case referred to medical	1			26. PI	ace of Death (C	1 Yes	2 No	1 L Yes	2 No	====
Zit 9	ysicia is cert direct	To Be	examiner? 1 🗌 Yes 2 🗘 No	Hospital:	ient 2 🗆 E	R/Outpatier	Oth		Home 5 Resid	dence 6	Other (Speci	fy)	
o	ng Ph fter th ineral		27. Manner of Death 1 Natural 5 Pending	28a. Date of inju (Month, Da		28b. Time of injury	28c, Injury work	?	28d. Describe h	now injury o	ccurred		*
ion	ttendi death. tor: A the fu	Certificate:	2 Accident Investigat 3 Suicide 6 Could not	t he	^4 han	no form otro	_	Yes 2 □ No	206 Leastine 6	Direct and A	lumbar or Pur	al Route Numbe	ar.
Division of Vital Records, P.O. Box 687	after of Direct In by	Cer	4 Homicide determine	building, et		ne, iann, sue	eet, factory, office		City or Tov		iumper or nar	ai noble Numbe	',
	ospita hours ineral d filled	Medical	29a. Certifier 1 Certifying Pl	hysician: To the best of	my knowle	dge, death o	occured at the time	, date and place	e, and due to the ca	iuse(s) and i	manner as sta	ted.	ner stated
							ne cause(s) a	nd manner as	stated.	ioi stated.			
_	Mit To COT		29b. Signature and title of certifier	160			29c. License	014/6	<u></u>		signed (Month		
J			30. Name and address of person who	b completed cause of c	death (Item)			11	•			- 1 -	
10	bb		Robert J. Bau	ier, M.D.	2810	3 Thre	ee Notch	Rd., Me	chanicsv	ille,	MD 206	559	
	Sta		31. Date filed (Month, Day, Year)	2010 32. Registr	ar's Signatu	ire A	have						
	Registr	ar	307. 9 0	2019		1. 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^D2010 July 11, John J. Andrusis 19:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Hours Min 0170371939 193-30-2955 Director PA Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director PA 1 Yes 2 XNo Dallas Luzerne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 68 Oak Drive 18612 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Year or Dates 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) High School Business Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o Alfreda Skibinski Justin Andrusis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Martha Phillips Andrusis, Wife 68 Oak Drive, Dallas, PA 18612 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mt. Olivet Cemetery 107/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Carverton, PA 21. Signature of Funer Service Licensee 22. Name and Address of Facility H. Merritt Hughes Funeral Home **-**Harman 451 North Main Street, Wilkes Barre, PA 18705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) executed Cause (Disease or iinjury 6)0M that initiated events resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 2 No 1 Tes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 20X No ဂ္ 1 Ø Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Division 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 00063220 2010

State Registrar

NORUSISIO

EAKE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2010 3:15 July Paula Balser /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cockeysville Baltimore Broadmead Medical Services, Inc. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 □ M 2 🖾 F New Jersey 94 Jan 15, 1916 077-36-2391 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Cockeysville Director MDBaltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21030 USA 13801 York Road Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2K No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 2 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry unk 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) and Mental Hygiene. social worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Floy Kepner Paul Leon Bassett ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
140 Riverside Drive; New York New York 10024 19a. Informant's Name/Relationship (Type. Print) Department of Health ar important: If item 27 is any Injury or other trau once. Pages 1 and 2 Paul Balser - son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☑ Other (Specify) 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Owe (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use coptribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No certificate 1 □Yes 2 12 No marsard 25. Was case referred examiner? funeral director. to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🛭 🕦 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** OWN 20101:30pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NURSING AND MARYLA KEHAK PriNCE GROV 5. Social Security Number 6. Sex If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Wash. D.C. 1 M 2 F 579-90-8801 Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show WASHINGTON ns 23a or 28a-f sh must be notified NA 1 PYes 2 No Director Ave. NE. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with HELEN BUYNOUGHS LLSA. 20019 or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Blac \$ 3 Widowed 4 Divorced "natural" Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) JEDICAL Elementary/Secondary (0-12) College (1-4or 5+) NUISE HOLVATE INDUSTE 2111. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Trince Braum Messalonia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washing Code) 19a. Informant's Name/Relationship (Type. Print) Vila Mas Brown Nannie HEIEN Burroughs AVE. N.E. 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3831 Georgia Quenue XIV cc0278 23a. Part1. Letter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760 physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.0. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 3 ☐ Probably 4 Nnknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page perform certificate 2/ No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending Affer 1 Natural 5 ☐ Pending investigation (Month, Day Year) 24 hours after death.

Funeral Director: A etely filled in by the fu 1 Tes 2 No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical Exami within 24 the 29b. Signature 29d. Date signed (Month Day, Year) mpleted cause of death (Item 23a) Type, Print) 32. Registra 31. Date filed (Month Day State 62010 Registrar

0-04643	Please Type or Print in Black Indelible Ink. Ensure All Copies	s Are Legible. 201	0 2213					
JNK UNK	State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death Registrar	giene C C C	0 2210					
Physician/ Medical Examine	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year June 19, 2010	3. Time of Death 2345 hrs					
)	4a. Facility Name (if not institution, give street and number) Southbound Route 301 at Short Cut Road 4b. City, Town, or Location of Death Brandywine	4c. County of Deat Prince Georg						
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or gn DC DC					
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 Yes 2 No					
the Maryland a or 28a-f show : tiffed at once. Director	MD Prince George Ft. Washington 10e. Street and Number 10f. Zip Code	10g. Citizen of What Cou	-21					
r death with the or items 23a or must be notific.	3412 Gennene Lane 11. Marital Status 1 Never Married 2 Married 2 Married Armed Forces? 1 Never Married 2 Married 2 Married 2 Married Armed Forces? 1 Never Married 2 Married 2 Married Armed Forces?	ecify Yes or No- 14. Race - Ame	rican Indian, Black,					
s after deat ral", or ite niner must by Fun	3 Widowed 4 Divorced If Yes, Give Year or Dates:		lack					
36 in 72 hours han "natuu ijcal Exaur	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retire	ed)						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	8 Maintenance Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (George Thomas Brower	First, Middle, Maiden Surname)	Industry					
MD 212 nd 2 should be lith and Ments m 27 is mark an m 27 is mark To B	19a. Informant's Name/Relationship (Type, Print) Gregory Brower/Brother 19b. Mailing Address (Street and Number or Relationship (Type, Print)) 201 I St SW #V605	ural Route Number, City or Town, Stat						
ore, M jes 1 and 2 of Health If item 2 ther traur	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City o	r Town, State					
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-faht injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lat		Home, Inc					
Physician /Medical	23a. P. ad. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arrest, shock, or heart	Approximate Intervention Between Onset an Death					
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):							
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
T ansit	d.							
೭. ೄ ಡಿ	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delive	гу					
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be execut Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - traal Centrification: To Re Commisted by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	Month	Day Year					
P.O. Best hat the degree by the detached for the property of t		23e. Did tobacco use contribute to 1 Yes 2 ✓ No 3 Pro	o the cause of death?					
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by al director, page 2 should be detach.			utopsy findings availab completion of cause of					
of Vital Recing Physician: The land After this certificate funeral director, page for To Re Com		1 Yes 2 No 1 V	res 2 No					
f Vital Physician or this certi	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nullsing	Home 5 Residence 6 🗸 Oth	er: Scene					
Division of Vital Records, tall or Attending Physician: The law require and ared each. The law requirement of the conflicture has been sited in by the funeral director, page 2 should be refite at the Completen entities at the completeness.	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 2327 hrs 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred Pedestrian struck by auto						
Division or spital or Attending nours after death. neral Director: After filled in by the fune.	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	28f. Location (Street and Number or R or Town, State) Southbound Route 301 at Short C						
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the I		the time, date and place, and due to	the cause(s)					
F % F 8	29b. Stignature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (M June 20, 2010	onth, Day, Year)					
11	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201						
Stat Registra								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 22132 10-05262 Jason William Boucher 1- For State Certificate of Death Reg No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death Physician/ 2109 hrs **Medical Examiner** July 13, 2010 William Jason 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laplata Charles Civista Medical Center 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number **Funeral** Country)
Louisiana Months Days Hours 38 Director 439-08-7189 02/08/1972 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10a State 1 Yes 2 X No 28a-f show Zellwood Florida Orange or items 23a or 28a-f sho must be notified at once. death with the Maryland rector 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 32798 United States Evergreen Road Ö 3309 unera 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married Married Yes 2 X No Specify: White 4 X Divorced Yes, Give Year 1 Yes 2 X No specify: 3 Widowed <u>۾</u> or Dates 16b Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natur. 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical timore, MD 21215-0036 Time Shares Sales 5+ Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fay Farris William E. Boucher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) Evergreen Road, Zellwood, Florida 32798 William E. Boucher, Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) or other 1 Burial 2 X Cremation 3 Removal from State rtment o 7/15/2010 |Baltimore, Maryland Metro Crematory, Inc. 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facilit Cremation Society of Maryland À 299 Frederick Road, Baltimore, Maryland 21228 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Cardiac Arrhythmia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Inhalation of Difluoroethane Sequentially list conditions, Due to or as a consequence of if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical 23a,b,27,28a-f per me g906 8-10-10 vt AMENDED X UNPENDED 68760, ing phys as the b 23c. If yes, outcome of pregnancy 23d, Date of deliver 23b. Was decedent pregnant in the Day 1 Live birth 3 Ectopic pregnancy Year Fetal death Month past 12 months' Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 Unknown Unknown the signed by the be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o . Ş 1 Yes 2 No 3 Probably 4 Unknown σ. Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? certificate ✓ Yes 2 No 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: of Vital Be examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes ဥ 28c. Injury at Work? 28b Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year Certification: 1 Natural 1 Yes 2 X No Subject inhaled Difluoroethane Division hours after death. Pending 7-13-10 8:45 pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3145 Crain Hgwy. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 Could not be Suicide within 24 hours a determined (Specify) hote1 4 Waldorf, Charles Co., 206D1 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated

State

29b. Signature and title,

Laron Locke MD.

ell 30. Name and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner

32. Registrar

Registra

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 22 | 33 State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 34 PM MELVIN BALDWIN 010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 **X** M 2 □ F Months Days Hours Min. 1943 Hamlet Director 577-56-7625 67 June Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director DC 1 K Yes 2 □ No Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 20019 1154 Sumner Road, SE USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc ģ 1 Never Married 2 Married ☐ Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2x No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Waiter Private Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edna Mae Ouick Lensy Baldwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9700 Lakepoint Court, #204, Upper Marlboro, MD 20774 Jennifer Baldwin - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State July 19,2010 Waldorf, Maryland 4 Donation 5 Other (Specify) Heritege Park Cemetery 21. Signature of Funeral Service Licen Johnson & Jenkins Funeral Home 22. Name and Address of Facility 716 Kennedy Street, NW, Washington, DC 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a const quence of): Examine Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the bunal-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Day Year the 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy page 2 performed 1 ☐ Yes 2X No 2 🔀 N 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No director, B 26. Place of Death (Check only one Hospital: Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🛚 Natural injury 5 Pending Investigation Accident 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and little of certifier 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar 3001 Hospital Drive, Cheverly, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Karen R. Brooks, MD,

162010

31. Date filed (Month, Day, Year)

100442183

6

20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2010. 22134 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Caro1 Brothers Ann July Pey. 2010 01:40amM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carrol1 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Min. 1 □ M 2 🏋 F Hours Feb. 7, Year) 946 Director 239-74-7543 64 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Finksburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3893B Sykesville Road 21048 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 72 hours after ☐ Yes 2 - XVo 1 ☐ Yes 2 ☐XNo Specify: and Mental Hygiene.

is marked other than "natural", If Yes. Give 3
Widowed 4
Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Day Care Day Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Baumes Anna Kindig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Calvin W. Brothers (Spouse) 3893B Sykesville Road, Finksburg, MD 21048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Providence Cemetery 7/15/2010 Gamber, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee Hord Duar & PO Box 195 Sykesville, MD 21784 MOO 764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final CHROMICOBSTRUCTIVE PUMERMY DISEASE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of, Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death signed by the a d be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? Completed by Beanchiec Msic 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b MUCOBAC FERIUM AVION Complex 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) Medical 29a. Certifie 1 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Description Surse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rance K. D31660 12/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26020

State Registrar HOMAS

K-

ALUW

2011

STONER AVENUE

LUESTAMSTER MAKERINE

in mo

32. Registra s Signa fire

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death 500 M Baquell Wyatt Brueckmann 07 2010 LD 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) land Medical Center Baltimore City Baltimore University of Man 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. 1 M 2 □ F 7/10/10 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a State 1 Yes 2 □ No Mt. Airy MD Carrol1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21771 712 Park Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amy R. Brueckmann Bagwe11 Virgil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 712 Park Avenue, Mt. Airy, MD Ms. Amy R. Brueckmann (Mother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/2010 Mt. Airy, MD Pine Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenşee PO Box 195 Sykesville, MD 21784 MO0764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 90 minutes xtrem. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the 20nce.

Physician

/Medical

Director

Funeral

Completed by

Be

2

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the "Actical Examinar must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Completed Be

Physician/Medical þ Certification: To

sician and burial-trans the attending physician ned for use as the burial signed by t I be detach ficate has been siç r, page 2 should b certificate this After t the Funeral Director: Af Medical

the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

9 ☐ Unknown	9 H OHKHOWH									
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	g cause given in Part I.		use contribute to the cause of death? □ No 3 Probably 4 Unknown					
				24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
25. Was case referred to medical		26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)					
27. Manner of Death 1 ☑-Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred					
3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, fact	28f. Location (Street a City or Town, Stat	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause(curred at the time, date ar	s) and manner as stated. Indicates the state of the state					

29c. License number

St Baltimore

1942435086

MD

21201

29d. Date signed (Month, Day, Year)

07,10,2010

within 2.

A. Fleming 31. Date filed (Month, Day, Year) State 162010 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene 22 32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 5:45PM Meyer R. Borghese ulu 3 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Multimedical Center mootor KA Baltimore Towson, Maryland
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 21204 8. Date of Birth (Month, Day, Year) 8/26/1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Numbel 212-01-6505 **Funeral** 1**XX**M 2□ F Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show 1 ☐ Yes 2 XXVo Baltimore Timonium Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21093 2309 Spring Lake Drive U.S.A. 'natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, Item Medical Execution. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√No Specify. Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) <u>Engineer Planner</u> Aerospace 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pietro M. Borghese Anna Tringale ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Whitehouse, NJ 08889 20 Plantation Road Robert N. Borghese / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition %Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Mem 7/17/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of): Physician months-years disease or condition resulting in death) /Medical Examiner years Atherosclerosis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are ultimated to the control of the contr Due to for as a consequence off Examiner months -Hupertensian

Due to (or as a consequence of): lears and resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Non ST segment myocardial infarction 6/2010 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? Benign Pratatic Hypertrophy 24a. Was an Dysphagia autopsy performe History of Urinary Tract Infection GOUT 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Nuise Practitioner: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760. Hospital or Attending 24 hours after death. after death. within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

DV Registrar 29b. Signature and title of certifier

29c. License number

R097104

RNP Genesis Multimedical Center 7700 York Rd. Towson, Maryland 21204

29d. Date signed (Month, Day, Year)

and manner stated.

whender CRUP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>6:10</u> ₽ ^M Mollie Rubinstein Burke Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Davs Hours Min. (Month, Day Months Sept. Ï921 **Director** 063-12-4475 88 New Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director 28a-f 1 ☐ Yes 2 🛣 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be 23a Funeral 8133 Seneca View Drive 20882 USA items 2 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11 Marital Status event, the Medical Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: White res, Give Year or Dates. 1942–1945 Completed 3 K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry within 72 than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Max Rubinstein Mary Levenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Barry Burke / Son 8133 Seneca View Drive Gaithersburg, Maryland 20882 other 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State injury or Judean Gardens 4 Donation 5 Other (Specify) 07/14/2010 Olney, Maryland 21. Signature & Funeral Service Licens 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, Inc 300 W.Montgomery Avenue Rockville, Maryland 20850 'n Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Hypertensive Heart Disease Medical resulting in death) Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, Examine Quality for each a consequence of if any, leading to immedicause. Enter Underlying The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Diabetes Mellitus and Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 for use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Pregnant at time of death Other (specify) signed by the a d be detached for g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Advanced Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 autopsy performed? After this certificate has Hospital or Attending Physician: 25. Was case referred to medica director 26. Place of Death (Check only one) Be examiner? Other: 4 🗵 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) Hospital 1 ☐ Yes 2 🛣 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 X Natural 5 Pending 24 hours after death. Funeral Director: A ☐ Accident Investigation the 6 Could not be To the Hospital or Atterwithin 24 hours after der To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

rack

50 West Edmonston Drive #207

D0047330

07/12/2010

20852

Rockville, Maryland

· JUSUAL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Swomus

Thomas Joseph, M.D.

16201

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22138 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 010 J_{u}^{Month} 13, Joseph Thomas Boquel 1:20P Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death 3805 Woodhaven Lane Bowie Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 № M 2 □ F Months Days Hours Min. 57 March 27, 1953 212-64-1200 Washington, D.C. **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's Bowie 1
¥ Yes 2 □ No 10e, Street and Number 10f. Zip Code 0 10g, Citizen of What Country? 23a Funera 3805 Woodhaven Lane 20715 United States or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: "natural", If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Construction Superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Peter Boquel Mary Elizabeth McCool traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard Boquel/Brother 215 Autumn Wind Way, Rockville, Maryland 20850 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite July^{Dat} 15, Montgomery Crematorium, Inc. 1 \square Burial 2X Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland Rockville, Maryland 20850 21. Signature of Funeral Service Licensee any Con M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Metastatic Lung Cancer disease or condition resulting in death) year Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): physician and s the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 certificate has director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

IUV

State Registrar

Medical

29a. Certifier

29b. Signature and title

Frederick Smith,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0033293

29d. Date signed (Month, Day, Year)

July 15, 2010

29c. License number

5454 Wisconsin Avenue, Chevy Chase, Maryland 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Edward Bundy Sr. 2010 Robert 14 A^{M} July 8:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2515 N. Snyder Avenue Baltimore Sparrows Point 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) January 9, 1948 Director 247-86-0675 62 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Md. Baltimore Sparrows Point 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2515 N. Snyder Avenue 21219 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Importants if item 27 is marked other than any injury or other trainments. Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Finisher Dry Wall Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Harry William Bundy Edith Leona Stebbing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Bundy Jr. Son 3116 Green Hill Road, Baltimore, Md. 21219 20a. Method of Disposition July 17, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 4 Donation 5 Other (Specify) Baltimore, Maryland 2010 21. Signature of Funeral Service Licenses Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md Part 1. Enter the disease, of domplications that caused the death, so not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1, Enter the disease Immediate Cause (Final Onset and Death MING DISEASE Physician OBSTRUCTIVE HROW! C disease or condition - Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): anding physician are as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASBESTOSIS 2 No 3 Probably 4 Unknown Completed ALCOHOL ARUSE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 : autopsy performed 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work?
1 Yes 2 No thin 24 hours after death.

the Funeral Director. Af
empleted filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who complete

6

DV

cause of death (Item 23a) (Type, Print)

UD

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2010

HOWARD.

41)21050

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month O 1 Physician/ 2010 153 lina Copleu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Manufand Medical Center Social Security Numbelln K If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Nov 30 Day, Mary Yand 38 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2🏝 No Prince Georges Brentwood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20722 4713 Allison Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Forces? Black, White, etc. 1 Never Married 2 Married þ white 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Uni (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Sandra Canterbury Paul Copley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Copley - mother 9000 Briarcroft Lane #321; Laurel, MD 20708 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify) in state 22State Afractary Board; 655 W. Baltimore Street ice Licen Director Baltimore, Maryland 21201 23a. Park 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset Ind Death Immediate Cause (Final Physician/ Pulmonary embolu disease or con Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Lue to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy
performed?

1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 25. Was case referred to medical 26. Place of Death (Check only one) B B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 욘 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title Rubecca 29d. Date signed (Month, Day, Year) 29c. License number Krochmal 06/2010 P24327 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kebecca 22 2120 Battinone MD Krochmal Si Greene 31. Date filed (Month, Day, Year) 32. Registar's Signature State 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 22 14 1 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Registrar	_	g. No.			
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death 1825 hrs		
wedicai Examin		Robert Roy Cotton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	July 13, 20	4c. County of D			
		Atlantic General Hospital Berlin		Worcester			
Funeral Director	l	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. And 12 F 64 Yrs. Age (In yrs. last birthday) Anoths Days Hours Min.	-	2/1946	Birthplace (State or Foreign Country) New York		
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits		
È ,	<u>_</u>	Maryland Worcester Berlin			1 Yes 2 X No		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland bent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 10625 Griffin Road 10f. Zip Code 21811		g. Citizen of What United	ŕ		
death with	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specific Vision Processes) If Yes, specify Cuban, Mexican, Puerto Forces		14. Race - A White, et	merican Indian, Black, tc.		
s after ral", o	⋧	3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of we	orle dona	Specify: 16b. Kind of Busine			
2 hour	ag-	Elementary/Secondary (0-12) College (1-4 or 5+)		160. Kind of Busine	ess/industry		
036 vithin 7 ene. er than Medica	Completed	12 Horse Trainer		Equestr	ian		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) 18. Mother's Name (Construction)			low		
212 buld be Menta marko c even		Roy Amos Cotton Corinne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru		n Crow ber, City or Town, S			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other transmissivene, the Mediuiry or other transmissivene, the Mediuiry or other transmissivene, the Mediuiry or other transmissivene, the Mediuiry or other transmissivene, the Mediuiry or other transmissivene, the Mediuiry or other transmissioners.	1	Kathy Oppito, Sister 26 Rozbern Drive.	Eatont	own. NJ	07724		
ore, ss l and of Heal		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - Cit	y or Town, State		
Baltimore, bernit. Pages I an Department of Hea Important: If itel	1	4 Donation 5 Other Specify: Metro Crematory, Inc. 7/15					
	-1	21. Signature of Funeral Service License Amanda Heaston 22. Name and Address of Facility Crem 299 Frederick Raod,	Baltim	ore, Mary	71and 21228		
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death		
Examiner	-	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):					
	اي	Sequentially list conditions, if any leading to immediate Due to for as a consequence of:					
		cause. Enter Underlying Cause (Disease or injury that initiated					
/ B is	Examine	events resulting in death) Last Due to (or as a consequence of):					
760, icate be executed physician and the burial - transit	Medical	d. UNPENDED AMENDED					
760, icate be physic the bur		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli			
Box 687 e death certific the attending p	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnan 4 Pregnant at time of death 5 Other (Specify)	су	Month	Day Year		
BOy e death the att	is L	1 Yes 2 No 9 Unknown 9 Unknown					
P.O. res that the signed by be detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death? Probably 4 V Unknown		
ords, we requires is been signature	Completed by	Chronic alcohol abuse, rectal cancer (clinical history)	24a. Was ar		e autopsy findings available		
COF	톍		autops perform	y prior ned? deat	to completion of cause of h?		
Vital Recysician: The l	ខ្ទី	25. Was case referred to medical 26. Place of Death (Check or	1 ✓ Yes 2	No 1 ✓	Yes 2 No		
Vita hysician direct	음 일	examiner?		Residence 6 0	Other:		
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as it	Ë	(Month, Day, Year)	28d. Describe ho	ow injury occurred			
/iSior or Attend ter death virector: n by the	ă lä i	2 Accident Investigation 289 Place of Island At home form street feet on efficient visiting etc.	Of Location (St	root and Number o	r Rural Route Number, City		
Divisi pital or Att ours after de teral Direct filled in by	Certification:	Suicide Could not be determined (Specific)	or Town, Sta		Rural Route Number, City		
Hospi 24 hou Funer stely fil							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in the	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	the time, date a				
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed July 14, 2010	(Month, Day, Year)		
n	-	30. Name and address of person who completed cause of death (Item 23a)		July 17, 2010			
2		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	1201				
	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature					
Registr	ar	JUL 162010 Cenus & Sagel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 0 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Ε. Coo1 10^{Day} Shirley 2010 6:30PM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 409 Ross Drive Sykesville 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country)
 LTV 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 1 □ M 2 🗓 F 72 Nov. 4 Year 1937 WV Director 232-60-0494 Yrs. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sykesville MD Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21784 409 Ross Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give White 3 V Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Dietary Supervisor State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Aulda Mathes Gay Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3625 Cemetery Lane, Westminster, MD 21158 19a. Informant's Name/Relationship (Type, Print) Mr. Kevin Cool (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Springfield Cemetery 7/15/2010 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUENRAL HOME & CHAPEL, PA M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications 1 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Physician/ Stage disease or condition resulting in death) year Medical Due to (or as a consuluence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician if or use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral Completed filled in the Funeral Completed filled in the second ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Number Practiciner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and in anner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

STONEY

32. Registrar Signat

Avenue

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

291

CHACKO

NU

B1. Date filed (Month, Day, Year)

2010

MO 21157

Westmunter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8: 45 AM 2010 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care-Irvington Baltimore 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min Month, Day, Ye 80 Alabama 1929 Director 420-30-3126 Usual Residence of Decedent show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🗆 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21229 United States 22 S. Athol Avenue Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces's Black, White, etc. 5 1 Never Married 2 Married Yes Give 2 | No 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates. Ko rea 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hauling 12 Truck Driver Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edith Beatrice Enis John Dewey Cain, Sr of Health and Nitem 27 is ma 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Garrett /Daughter 104 Zephyr Lane Winchester, VA 22602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jul 13 permit. Page 1 a
Department of IImportant: If ite
any injury or ot
once, 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 21. Signature of Funeral Service Lice 22. National Alternatives Ka 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ema Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 🗌 No the a detached 9 Unknown 9 Unknown n signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the upperlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed To the Hospital or Attending Physician: The law require within 42 hours after death. To the Funeral Director. After this certificate has been sit completed filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 - No ၉ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending ✓ Natural 1. Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

(Month,

need

AHME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N

32. Registrar's Signatur

Ecloui

29c. License number

29d. Date signed (Month, Day, Year)

2010

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			For State Registrar	State of Ma	aryland		artment of H <i>tificate of D</i>		Mental Hyg ห	iene _{eg. No.} 201	0	22144
	DI	,	1. Decedent's Name (First, Middle, Las	st)					2. Date of Deat	h		3. Time of Death
	Physicia Medic		Timothy	s.			Craft		July 15	, 2010	ar	4:20 A M
	Examin	er	4a. Facility Name (if not institution, give					Location of Death		4c. County of D		
7 4	·		Stella Maris Hosp. 5. Social Security Number 6. S		e (In yrs. last	hirthdayl	To	WSON If Under 24 Hrs.	8. Date of Birth	Baltin		ace (State or Foreign
	Funeral Director			∑ M 2 □ F	46	Yrs.	Months Days	Hours Min.	Month, Day, July 16	Year) , 1963 N	Country	land
	and show at	o	10a. State 10b. County		10c. City, T	own or Loc	cation				10	d. Inside City Limits
	/anyla 8a-f s tified	Director	Maryland Baltim	ore		Dund	alk					1 ☐ Yes 2 ☐XNo
	the Na or 2	٥	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What	Countr	y?
	h with	Funeral	7333 Berkshire Ro				2	1224		USA		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Wldowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐X If Yes, Give Year or Dates.		li li	Vas Decedent of His f Yes, specify Cubar ☐ Yes 2 🟋 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:		c.
5-0	2 hou "natu adica	plet	15. Decedent's E (Specify only highest gr	ducation ade completed)	1	16a. Deced	lent's Usual Occupa	ation urina most of work	ina	16b. Kind of Busine	ess Indu	ustry
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<u>a</u>	l be fil fental rked tic ev	P.	Lonnie Craft					Sandra M				
ary	should and N is ma		19a. Informant's Name/Relationship (7)		110					City or Town, State		,
Σ.	nd 2 seath m 27 ner tra		Sandra Craft	mother			Berkshire	Road, D	undalk,M	aryland	212	22
Baltimore,	. Page 1 a tment of H tant: If ite jury or otf		20a. Method of Disposition 1 → Burial 2 → Cremation 3 4 → Donation 5 → Other (Special Contents)	Removal from State	20b. Plac cem Meac	dowri	sition (Name of natory or other place dge	: 20	19 , 10 н	20c. Location - City alethorpe	e,Ma	
Ball	Depart Impor any in		21. agnature of Funeral Service Licens	Conne	elle	22 C 7	Name and Addres Onnelly F 110 Solle	s of Facility Uneral H ers Point	ome Of D Road, D	undalk,P. undalk,Mo	A.	1222
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	1	Approximate Interval Between							
المستد	Ph _y sician/ Medical	X X	Immediate Cause (Final disease or condition resulting in death)	a. MULTIPLE							1 (Onset and Death
	Examiner		resulting in death)	Due to (or as a	consequen	ce of):						
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequen	ce of):					+	
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Box 68	death certific e attending p ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant at 9 Unknown	2 🗀 Fetal de	eath 3 🗌	Ectopic pregnancy Other (specify)	ý		23d. Date of Month		y Day Year
0	t the	Phy	g □ Unknown Part II. Other significant conditions c		ut not ropulti	ng in the u	ndorhing oguso give	on in Bort I	00 0011111			
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He.	hysician: The law nis certificate has I director, p. ge 2 s	Com							perform			
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ice of Death (Chec	k only one)			
<u></u>	Physic this c	2	1 ☐ Yes 2 🛣 No 27, Manner of Death	1 Inpatie		Outpatien b. Time of	t 3 DOA Othe	4 ☐ Nursing Ho		nce 6 X Other (S)	oecify)	HOSPICE
0 0	tth. : After e fune	cate	1 👿 Natural 5 □ Pending 2 □ Accident Investigation	(Month, Day	Year)	injury	work's		28d. Describe ho	w injury occurred		
Division of Vital	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, pcge 2 should be detached for use as	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			, farm, stre	eet, factory, office		28f. Location (Str City or Town,	eet and Number or , State)	Rural R	Poute Number,
	re Hospit n 24 hour le Funera	Medical	(Check 2 Medical Exam)	sician: To the best of r ner: On the basis of ex se Practioner: To the b	amination ar	nd/or invest	igation, in my opinio	n, death occurred a	t the time, date and	d place, and due to t	he caus	e(s) and manner stated.
_	To the within confine	_	29b. Signature and title of certifier	1.0			29c. License	number	29	9d. Date signed (Mc	onth, Da	ay, Year)
)		* JAKING C	INT			KIY	1792		1/15/	20,	10
	61		30. Name and address of person who could JACKIE JONES, CRN					I'IMONTUM,	MD 2100	93		
	Stat Registra		31. Date filed (Month, Day, Year) JUL 16 20	32. Registra			0.41					
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JULY 15, 2010 4:20 a.m.

TIMOTHY CRAFT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frank Joseph Caporusso, Ju₁y 2010 6:50PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bedford Court Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 19, 6. Sex If Under 1 Year **Funeral** 9. Birthplace (State or Foreign New Jersey 1 ፟ M 2 □ F Months Days Hours Min. Director Yrs. 140-18-7866 87 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10d. Inside City Limits 1 ☐ Yes 2 🕅 No Maryland North Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14512 Antigone Drive 20878 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced Year or Dates WWII White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) Callege (1-4 or 5+) 12 Factory Worker Manufacturing permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumation once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carmine Caporusso Dora Dapollo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank J. Caporusso, Jr./ Son 14512 Antigone Drive, North Potomac, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Montgomery Crematorium Inc. July 14, 2010 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland Pumphrey Funeral Home/ 2,755/ Wisconsin Avenue 22. Name and Address of Facility Robert A. Sethesda-Chevy Chase. Inc Bethesda, Maryland 20814-Signature of Funeral Service Licensee Dother the M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 100 settand Death Clostridia Gastroenteritis Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year Yes 9 Unknown 9 🗆 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinson Disease 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed peen Biliary Obstruction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed? Yes 2 No Renal Failure 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🗓 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 K Nursing Home 5 Residence 6 Other (Specify) this Director: After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 - Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral Detect filled Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address deperson who completed cause of death (Item 23a) (Type, Print)

Arthur Schoengold, M.D.

31. Date filed (Month, Day, Year)

6

D18726

18111 Prince Philip Drive #T-10, Olney, Maryland 20832

July 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 44P M ECKER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Square Hospita more If Under ge (In vrs. last birthday) If Under 1 **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 🖊 2 🗆 F Months Min 06/02/1946 Georgia 253-70-1351 Director 64 Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10a. State 10b. County with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 ☐ Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1827 Kittyhawk Road 21221 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. o, þ 1 Never Married 2 Married Yes 2 X No **Maryland 21215-003**6 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Enamel Manufacurer of Health and Mental Hygier If item 27 is marked other tr other traumatic event, the Air Filter Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Austin Decker Lillie Mae Bass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Wanda Decker (Wife) 1827 Kittyhawk Road, Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ð 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Bayview Crematory, Ind07/16/2010 4 Donation 5 Other (Specify) Baltimore, Maryland Service Licensee 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 old Eastern Avenue, Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death ORONARY disease or condition resulting in death) Medical Examiner REBROVASCUL Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of ABETES attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical VASCULAR Division of Vital Records, P.O. Box 68760 IF FEMALE: igned by the attendin be detached for use 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Month Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has performed? Yes 2 No 1 🗌 Yes 2 🗆 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Toleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DLHOSH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

PC

o-osoos oseph Paul Doy	/le	State of Maryland / Department of Health and Mental I		•	0011
		1- For State Control of Treath and Wentan Certificate of Death	, ,	2010 Reg. No.	22147
Physicia		Decedent's Name (First, Middle,Last)	2. Date of Dea Month	ath	3. Time of Death
dedical Examir	ner	1	July 4, 20	010	0449 hrs
,)		4a. Facility Name (if not institution, give street and number) Prince George's Hospital Center 4b. City, Town, or Location of Dea Cheverly	ath	4c. County of Dea	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	Irs 8 Date of Bi	irth(MM/DD/YYYY) 9. E	
Director		443-80-2443 1X M 2 F 28 Yrs. Months Days Hours M	in.	Fore	eign
		Usual Residence of Decedent	08/14	/1981	OK OK
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show 1 at once.	힏	District of Columbia Washington, D.C.			1x Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What Co	untry?
ith the		1750 S Street NW 20009 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (3)	0'f-VN	USA	de la la la Blada
death w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer		14. Race - Ame White, etc.	erican Indian, Black,
fter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: W	nite
ours a	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business	
72 h	olete	Elementary/Secondary (0-12) College (1-4 or 5+)	,	1	
5-0036 led within 72 hours afte Hygiene. other than "natural",	Completed	7 3rd Year Law Student (Int 17. Father's Name (First, Middle, Last) 18. Mother's Nam	em)	Law Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C		izabeth Fa	,	
21.	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			te, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ļ	John Mark Doyle (Father) 2620 Curminos Drive, Oklah			
or Hez		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	r Town, State
Baltimore, Department of He Important: If ite		4 Donation 5 Other Specify: Resurrection Cametery 7/9	/2010	Oklahoma Cit	y, OK
Balt permit. Depart Import		21. Signature of it neral Service Licensee 22. Name and Address of Facility Ma			иœ
Physician	\dashv	3925 N. Asbury Bethan 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple injuries			Between Onset and Death
Examiner	-	or condition resulting in death) Due to (or as a consequence of):			
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			-
	틝	cause. Enter Underlying Cause (Disease of minu) that initiated			
ig e o	Examiner	events resulting in death) Last Due to (or as a consequence of):			
	ical	d. X UNPENDED AMENDED			
	led led	23a.27.28a-f.per ME g905 7/29/10 IF FEMALE: 23c. If yes, outcome of pregnancy	TT	23d. Date of delive	l rv
Box 68760, death certificate be the attending physical for use as the burnary of for use as the burnary death of the control o	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn	nancy	Month	Day Year
eath certific	sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown		1	
O. B at the de		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
, P.O.	a P		1 Yes	s 2 No 3 Pro	bably 4 Unknown
ords v requi s been should	leted		24a. Was autop		utopsy findings available completion of cause of
The law ate has age 2 sl	Compl			rmed? death?	
Vital Reconstitute Vital Reconst	ည္	25. Was case referred to medical examiner?			LJ
of Vital Records, ing Physician: The law requin Wher this certificate has been si	일	1 Yes 2 No Tospital 1 Inpatient 2 FR/Outpatient 3 DOA Outel 4 Nursi		Residence 6 Othe	
n of liding Ph. h. After t	ᇹ	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending 7 / / 10	subject train	how injury occurred Struck by	metro
Division ral or Attendi	<u>[</u> g	2 X Accident Investigation //4/10 10254 hrs 28e Place of Injury - At home farm street factory office building etc.		Street and Number or R	ural Route Number, City
Divi spital or , tours after neral Dir filled in I	Certification:	Suicide 4 Homicide Could not be determined (Specify) metro station	or Town, S	State) 4120 Mir.	nesota Ave
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only)			ted.
To the Hospital Within 24 hours To the Funeral completely fille	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	and place, and due to t	he cause(s)
L > F 0	žΓ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
d		COMME.		July 5, 2010	
X	1	 Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21 	1201		
Cin		31. Date filed (Month, Day, Year) 32. Register's Signifiure	1201		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Walter Andrew Davison 10:09 PM July Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3779 Eagle Ridge Court Carroll Hampstead 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 12, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Hours Min. Maryland Director 78 Yrs 213-28-2398 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo Maryland Carroll Hampstead 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? United States Funeral 3779 Eagle Ridge Court 21074 America 12. Was Decedent Ever in U.S.
Armed Forces? 194
144 Yes 2 \(\text{No}\) No
If Yes, Give 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1947 Black, White, etc. ģ 1 Never Married 2XX Married Maryland 21215-0036 1 Yes 2 No Specify: 1952 Specify: 3 Widowed 4 Divorced Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 7: ment of Health and Mental Hygiene. tant: If item 27 is marked other than ury or other traumatic event, the M6 Elementary/Seconday (0-12) College (1-4 or 5+) 12th Meat Cutter Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward Davison Edith McNeave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Walter S. Davison (Son) 3779 Eagle Ridge Court, Hampstead, Maryland 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jul^{Date} 17 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 2010 Baltimore, Maryland 21. Signature of Fundal wice Licer. 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. exmau 3296 Charmil Drive, Manchester, Maryland 21102 fol. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) DEMENITA 5 YEARS ADVANCED Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atter in the past 12 months? Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, HYPERLIPIDEMEA Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number MMD

State

Registrar

ttano

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

View

Grand

31. Date filed (Month, Day, Year)

16201

Rd

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4c perPHYS, G905, 7716/2010, WS
State of Maryland Department of Health and Mental Hygiene 0 0 22149 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Joe Cleve Daugherty $6:35 P^{M}$ Medical 201 Tull 4a. Facility Name (if not institution, give street and number) ounty of Death

Baltimore

Baltimore **Examiner** Greater Baltimore Medical Center Towson **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 1924 1**XX**M 2 □ F Months Hours Director 266-26-7749 Tennessee Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits 1 Yes XX No Baltimore Maryland Sparks 10e. Street and Numbe 10f. Zip Code Og Citizen of What Country?
United States Funeral 5B ShelbysPath 21152 America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1XXYes 2 \(\square\) No Black, White, etc. 1 Never Married 2XX Married filed within 72 hours after Completed by 1944 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8th Truck Driver Maryland Transportation Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental 2 Cleve Daugherty Callie Hensley permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne Daugherty (Wife) 5B Shelbys Path, Sparks, Maryland 21152 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JuZy 16, A11" Fa1th's Crematory & Chape1 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Manchester, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. onatur of Funeral Service vicens 11605 Reisterstown Road, Owings Mills, MD 21117 Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Physician/ disease or condition Medical resulting in death) r as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed Yes 2 certificate 1 Yes 2 No 25. Was case referr Be 26. Place of Death (Check only one) examiner? Hospital 2 100 ျ 1 Tyes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b Time of 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending atural Accident 1 Tes 2 🗌 No Investigation Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 124 hours after of Funeral Direc 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, dress of person who completed cause State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Douglas Kay Dove Medical July 2010 5:45 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gildhrist Center Towson Baltimore Social Security Number 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 218-98-5478 May 13. 1966 Maryland Usual Residence of Decedent 2 should be filed within 72 now...
th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show
27 is marked other than "natural", or items 23a or 28a-f show
27 is marked other than "natural", or items 23a or 28a-f show
28a-f show 10b. Coun 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8301 Oakleigh Road 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: 3 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baker Bakery 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Kay Dove Margie Ann Mabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 is Margie Dove (Mother) 8301 Oakleigh Road Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State July 17, 2010 Evans Funeral Chapel-Rel Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

23a. Part 1. Enter the disease, or complications that caused shock, or he at failure. List only one cause on each line. 2. Name and Address of Facility Evans Funeral Chapel & Cremation Services Parkville 8800 Harford Road Parkville, Maryland 21234 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ Vig disease or condition resulting in death)) Medical Due to (or as a prinsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sig , page 2 should b 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed certificate 2 No Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? å funeral director, 26. Place of Death (Check only one) 2 🗆 No Hospital: Other: 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending hours after death.

neral Director: Aff 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотретер Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signarure State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.0.

Records,

Division of Vital

10-05118 Antonio Dipinto

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 22151 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Medical Examiner** Antonio Dipinto 1247 hrs July 8, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 25 1 M 2 F Country) 09.20.1984 MD <u>unk</u> Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 123 South Arlington Avenue 21223 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black Armed Forces? White, etc. 1 Never Married 2 Married White Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year Yes 2 No specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Antonio Leonard Depinto Be Faith Ann Paxton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore 123 South Arlington Ave <u>Faith Ann Myer/Mother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 07.13.10 Beltsville, Donation 5 Other Specify 21 Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 8717 Green Pastures Dr. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximale Interval Physician failure. List only one cause on each line, Between Onset and /Medical Death Cardiac Arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, pt.II, 27 per me g906 8-25-10 vt X UNPENDED the attending physician red for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? been signed b hould be detact ģ 1 Yes 2 No 3 Probably 4 V Unknown Schizophrenia Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate has page 2 s performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 1 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: / 5 Pending 1 Yes 2 No hours after death. Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) To the Funeral I determined the Hospital (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 9, 2010 O.C.M.E 30. Name and address of erson who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# I per PHYS# 5 per FH, G905, 7/23/2010, WS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last Miriam 2. Date of Death Fox **Eckels** Month Physician /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death **Baltimore** Catonsville Charlestown Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Hours 95 Yrs Director March 1, 1915 Pennsylvania Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the the fical Evaminer must be notified at Director 1 ☐ Yes 2 No Owings Mills 28a-f Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21117 4404 Silverbrook Lane, E-204 United States Funeral items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 □Yes 2 **X**No 1 Never Married 2 Married o. Specify: White altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: ð 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other that any injury or other traumatic event, Item 2000. Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Hallowell Tyson Marguerite Clara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott, Daughter 4404 Silverbrook Lane, E-204, Owings Mills, Maryland 21117 Grace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 7/15/2010 Baltimore, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee Amanda Heaston 22. Name and Address of Facili@remation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HIZKRIMEN disease or condition resulting in death) /Medical Due fo (or as a consequence of): Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) detached 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Cidni 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate performe 1 □ Yes 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner - eath 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who con pleted cause of death (Item 23a) (Type, Print) atmsville laiden hola 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2230 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Millersville 741 Panther Court 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Jan 20, 1940 Funeral 9. Birthplace (State or Foreign Months Days Hours Maryland Director 70 Yrs 212-40-1073 Usual Residence of Decedent shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other than "... any injury or other traumari... 21108 USA 741 Panther Court 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married white If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Wells Esther Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
741 Panther Court; Millersville, MD 21108 Robert Farley - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signatur | Funeral ²²Name and Address of Facility Board; 655 W. Baltimore Street rector Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faildire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Physician/ arcino Sakoma disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Exam -tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a thed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 pronths?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death Month Year Unknown ate has been signed by a page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed Yes 2 No 25. Was case referred to medica examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Hospital 1 🗌 Yes Other: 잍 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invertigation in my color 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practice To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of Date signed (Month, Day, Year) Name and address of per on who completed cause of death (Item 23a) (Type, Print) Aun 744

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2351 M STINA 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tate Hospice House Anne Arundel Linthicum If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. AUG 1Day, 1 M 2 Hours 1920 Director 579-56-1684 89 Germany Usual Residence of Decedent shov 10a. State 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral Germany 2503 Amber Orchard Court West, #304 21113 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Examiner ı Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Johann Lohrer Barbara Kramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gabriele U. Mecca, daughter 2503 Amber Orchard Ct. West, #304 Odenton, MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 07/16/10 | Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 200 Frederick Road Baltimore, MD 21228 Signature of Funeral Service Licensee George MacNabb 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Pear Physician, Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Die to (bras a consequence of, the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year 4 Pregnant
9 Unknown signed by the a d be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? e Hospital or Attending Physician: The 24 hours after death.

Funeral Director: After this certificate I ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2.12 No DICE မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral a 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [only one Certifying Nurse Practioner: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License numbe who completes use of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 22155

		1- For State Registrar	Certificate of	Death		Reg. No.	
		Decedent's Name (First, Middle,Last)			2. Date of De Month	Day Year	3. Time of Death 1422 hrs
dical Exam	ilner	Robert F. Ferguson 4a. Facility Name (if not institution, give street and number) 12	4b. City, Town, or Locatio	July 10, 2 on of Death	2010 4c. County of Deat	
		710 Whitmore Avenue	ĺ	Baltimore		N/A	
Funera			ge (In yrs. last birthday)	If Under 1 Year If Ur Months Days Hot		irth(MM/DD/YYYY) 9. Bi Forei	gn
Directo		216-09-5057 1XM 2 F	9 3 _{Yrs.}		06/09	/1917 C	ountry Maryland
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	on			10d. Inside City Limits
* .	_	Maryland N/A		Baltimore			1 X Yes 2 No
Maryland 28a-f show d at once,	Director	10e. Street and Number	1	10f. Zip Code	1	10g. Citizen of What Cou	intry?
vith the Maryland s 23a or 28a-f show e notified at once.	ä	710 Whitmore Avenue		2121	L6	United Sta	tes
th with ems 2.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces		s Decedent of Hispanic C es, specify Cuban, Mexic	Origin? (Specify Yes or N an, Puerto Rican, etc.)	lo- 14. Race - Ame White, etc.	rican Indian, Black,
ter dea		1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	2 X No	Yes 2 X No speci	fv:	Specify: B1	.ack
ours af atural	d by	15. Decedent's Education (Specify only highest grade co	mpleted) 16a. Decedent	t's Usual Occupation (Giv	ve kind of work done	16b. Kind of Business	/Industry
11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene, Anna Hygiene, and Indianary or items 23a or 28a-f she event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	ost of working life, DO NO	or use retired)	City of Ba	1timore
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	E	17. Father's Name (First, Middle, Last)	Plant		ner's Name (First, Middle,	_1	ITCIMOLC
215-(e filed tal Hyg ked oth	Be C	Robert F. Ferguson		Anı	_		
2121: hould be fill and Mental B is marked	일	19a. Informant's Name/Relationship (Type, Print)			umber or Rural Route Nu		
e, MD 1 and 2 sh Health and item 27 is		Robert F. Ferguson, V, Gran		Schley Avenu ition (Name of cemetery,	ue, Baltimor	ce, Maryland	
imore, MD 2 Pages 1 and 2 shoul ment of Health and M lant: If item 27 is m or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from S	crematory or oth	ner place)			
Baltimore, permit. Pages 1 ar Department of He Important: If ite injury or other tr		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee Amanda	Metro Creu	atory, Inc.	7/15/2010 Cremation S	Baltimore,	rvland. Inc.
Bal perm Depa Impo		Die leldo	290	Frederick	Road, Balti	more, Maryl	and 21228
Physiciar		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter th	ne mode of dying, such as	s cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
/Medica Examine		Immediate Cause (Final disease a Atherosclerotic	Cardiovascular Dise	ease			Death
		or condition resulting in death) Due to (or as a cons	equence of):				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	sequence of):				1
to	Examine	(Disease or injury that initiated events resulting in death) Last	sequence of):				
760, cate be executed physician and the burial - transit	ᇤ	d.					
D, be exe sician	Medical	UNPENDED AMENDED					
8760, tificate bug physicas the bun	W/U	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outco		tal death 3 Ecto	pic pregnancy	23d. Date of deliver Month	Y Day Year
Box 687 ne death certific the attending p	sician	1 Ves 2 No 0 Ulpknown	t time of death 5 Oth	ner (Specify)			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. For the or all the first his certificate has been signed by the attending physician and rely filled in by the funeral circetor, page 2 should be detached for use as the burial - transity.	P. P.	Part II. Other significant conditions contributing to dea	th but not resulting in the u	nderlying cause given in	Part I. 23e. Did	tobacco use contribute to	the cause of death?
s, P.O. iires that the signed by d be detach	<u>₹</u>					es 2 🗸 No 3 🗌 Pro	bably 4 Unknown
ords, w requir s been s should b	Completed				24a. Was		utopsy findings available completion of cause of
tal Records tian: The law requirectificate has been ector, page 2 should	E G				perf	ormed? death?	es 2 No
an: T	Be	25. Was case referred to medical			th (Check only one)		
of Vital Ing Physician: After this certificance and director.	To B	TV res 2 No	ent 2 ER/Outpatient			Residence 6 Othe	r: Scene
Division of Vital Records, tal or Attending Physician: The law requir as rater death. al Director: After this certificate has been seled in by the funeral director, page 2 should it.	ä	27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Inj (Month, Day)	ury 28b. Time of Ir Year)	njury 28c. Injury at Wo	_	how injury occurred	
ISION Attenor r death rector:	cati	2 Accident Investigation 28e Place of I	njury - At home, farm, stree			(Street and Number or R	ural Route Number, City
Divi	Certification:	Suicide 6 Could not be determined (Specify)	,	, ,	or Town,	State)	
To the Hospital within 24 hours a To the Funeral 1 completely filled		29a. Certifier 1 Certifying Physician: To the best of n	ny knowledge, death occur	red at the time, date and	place, and due to the cau	use(s) and manner as sta	ted.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or investigati				
	2	29b. Signature and title of certifier		29c. License numb	GI .	July 11, 2010	anni, vay, rear)
0				1			
1 1		30. Name and address of person who completed cause of	death (Item 23a)				
10		30. Name and address of person who completed cause of Margarita Korell MD. Assistant Medica		enn Street, Baltimo	ore, MD 21201		

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0

		-	State of Maryland / Dep State of Maryland / Dep Registrar Ce	artment of Health and N rtificate of Death	Mental Hygiene 20 0	22156
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia Medic		John Joseph Ferrario		$J_{\text{uly}}^{\text{Month}}$ 11^{pay} 20^{Year}	2:14 AM
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deat	h
			Anne Arundel Medical Center	Annapolis	Anne Aru	ndel
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M 2 F 9.4 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month Ray Year) - Co.	thplace (State or Foreign untry)
	Director		198-14-2481 1 X M 2 L F 84 Yrs. Usual Residence of Decedent		09/20/1925 PA	A
	nd how at	<u>_</u>	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	laryla 3a-f s ified	ect	FL Saint Lucie Jensen	Beach		1 ☐ Yes 2 🛣 No
	or 28		10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	
	with s 23a ust b	Funeral Director	10310 S. Ocean Drive, Apt. 602	34957	United Stat	tes
	leath item	필	Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.) 14. Race - Ame Black, White	
36	", or amin	ğ	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🎇 No Specify:	Didon, Trino	white
Ö	ours and trural	Completed	3 Wildowed 4 Divorced Year or Dates. WWII FIG			1
15	72 hc n "na ledic	힐	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki O NOT use retired)	ng 16b. Kind of Business	Industry
12	rithin rene. r thai	S	Flementary/Seconday (0-12) College (1-4 or 5+)	ales	Retail Sales	
0	Hygi othe	a)	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)	
lan	be fi lental rked tic ev	2	James Ferrario	Sadie	McDanaugh	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Department of Health and Mertal Hyglene. Department of the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or Rura	l Route Number, City or Town, State, Zij	o Code)
Σ	d 2 s alth a n 27 i er tra		Jackie Schraeder, Daughter 1042	Spa Road, Apt. L,	, Annapolis, MD 21	403
ore.	of He fitem		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposerery, cre	osition (Name of [matory or other place)	Date 20c. Location - City or	Town, State
<u><u>ĕ</u></u>	Page nent ant; I			ine's Cemetery 7/15/	2010 Moscow, PA	
alt	ppartr port y inj				ael Wargo Funeral Home	
		-17	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	812 E. Scott St., Olyp		
	ath certificate be executed The second of t	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	show		Interval Between Onset and Death 12 hows 2H hows
. Box 6876	e de the	Physician/Medi		Ectopic pregnancy Other (specify)	23d. Date of de Month	livery Day Year
P.O.	requires that the been signed by ' should be detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
S,	ires t sign Id be	q p	Hypertension.		1 ☐ Yes 2 ☐ No 3 ☐ P	robably 4 Unknown
ord	/ requ	Completed by	Hypertension. Atrial fibillation			topsy findings available
ec	The law cate has page 2 s	omp	J. W. T.		performed? death?	completion of cause of
듄	sician: The certificate rector, pag	Be C	25. Was case referred to medical	26. Place of Death (Check		3 3 3 1 1 1
Division of Vital Records,	nding Physician: T th. : After this certifica : funeral director, p	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Spec	cify)
ō	ig Ph ter th neral		27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Month, Day, Year) 28b. Time of injury injury	f 28c. Injury at work?	28d. Describe how injury occurred	
on	endir sath. or: Af he ful	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No		
/isi	Il or Attendi after death Director: A d in by the fi	erti	3	reet, factory, office	28f. Location (Street and Number or Ru City or Town, State)	ral Route Number,
ā	pital or ours afte eral Dir filled in					
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death	stigation, in my opinion, death occurred at	t the time, date and place, and due to the	cause(s) and manner stated.
	To the Hos within 24 h To the Fun completed	Š	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number	be, and due to the cause(s) and manner as 29d. Date signed (Mont	
-	1049		P 1 . / P.		111.	2012)
			30, Name and address of person who completed cause of death (Item 23a) (Type,	D39497	July 11 à	
	(al Parkway Ar	matolis Man	land
	/ Stat	e.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	The state of the s	
	Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:50 FM **Physician** Deborah 2010 W /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, . Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days 1 M 2 213-58-0766 **Director** Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show must be notified at 1 Nes 2 No Director more 10g. Citizen of What Country? 10e. Street and Numbe ō items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces injury or other traumatic event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or ite 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ederal Worker Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type Department of Health a Important: If item 27 Is any injury or other trains 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place, Burial 2 4 Donation 3 Removal from State 2 Cremation 2010 5 Other (Specify) 21. Signatu of Funeral Se Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the 23a. Part 1. Enter the diseas List only one cause on each line shock, or heart failure. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 Yes 25 No 9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No 2 🗌 No 1 Tyes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 2 No 3 🗌 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient ည filled in by the funeral 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P safter death. Certification: Division 5 Pending investigation Injury 1 🗌 Yes 2 - No Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide of the Hu. within 24 hours To the Funeral D' 'etely fille 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical

State Registrar

one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

treta 32. Registrar's Signature

and manner stated.

ND address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day BEATRICE ARCIA 2300 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 7. Age (In vrs. last birthdav. Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Year 19<u>38</u> 1 🗆 M 2 🗷 F Months Days July 17 Director 215-38-4964 71 Yrs Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? items 23a 3608 Village Drive, N. 20772 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: "natural" Completed Specify: 3 XWidowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Judicial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Plitt Julia Stump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11115 Sceptre Ridge Terrace Lisa Finotti, daughter Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 7/14/2010 Woodbine, Maryland 21. Sign e of Funeral Service Licen Going Hone Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ UKS disease or condition Medical resulting in death) D e to (or as a consequence of **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Directo (or as a consequence of) burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ANDRIN ၉ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28c. Injury at Certificate: 28b. Time of PICE 28d. Describe how injury occurred Director: After 5 Pending 10412 1 🗌 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Name and address of person who complete

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MD21401

ed cause of death (Item 23a) (Type, Pript)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Myron Hirsch Physician/ 10:15am M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Hospice Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) NY Social Security Number 120–12–5105 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🖾 🗸 □ F 772171920 89 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location **Funeral Director** NY Nassau Great Neck 1 Yes 2 ☐ No 10f. Zip Code 10e. Street and Number
3 Locust Street 10g. Citizen of What Country? 11023 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates white Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) 5+ Healthcare Optometrist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward E. Hirsch Minnie Sass 19a. Informant's Name/Relationship (Type, Print) Barbara Hirsch / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13910 Little Tree Court, Rockville MD 20850 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Beth Moses Cemetery 7/9/2010 Pinelawn, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LicenseeVictor P. Charles Lores Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Fungal Bactremia month "hysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner LungCancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burial Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🔀 No 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

To the within 2

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title

MD

knowana

29c. License number

person who completed cause of death (Item 23a) (Type, Print) use, MD 6001 Muncaster Mill Road, Rockville Maryland 20855

147123

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Clare G. Holmes Month 0145AM 2011 une Medical 4a. Facility Name (if not institution, give street and number) MeadowS **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Assisted Living Spring Montgonery Sandy Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Pay, Year) 6/14/19 084-12-0033 Months 1 M 2 F 91 Days Country) Director Yrs Usual Residence of Decedent shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery MD Sandy Springs 28a-f 1 Nes 2 No 10e. Street and Number ö 10f. Zip Code ral", or items 23a or Examiner must be 10g. Citizen of What Country? 1637 Hickory Knoll Road Funeral within 72 hours after death with 20860 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes ŽXX No If Yes, Give Baltimore, Maryland 21215-0036 nan "natural", o Medical Exan 1 ☐ Yes 2 📉 o Specify. white Completed ¥X Widowed 4 ☐ Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cleophas ည J. White Catherine O'Brien 19a. Informant's Name/Relationship (Type, Print)
Karen Jensen / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Monton St., Needham MA 02494 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trai 20b. Place of Disposition (Name of cemetery, crematory or other place)
St Mary's Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 7/19/10 1 ☐ Burial 2 ☐ Cremation → Removal from State MA Needham 4 ☐ Donation 5 ☐ Other (Specify) Victor Signature of Funeral ²Charledding of Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ erclorovascular disease or condition resulting in death) accident Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death ed by the a detached if 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Zheimer's disease Division of Vital Records, Completed 1 🗌 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy s certificate ha lirector, page performed? Yes 2 N 1 Tes 2 🗌 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: ည After this of funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5. Pending death. within 24 hours after death
To the Funeral Director. / Accident Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

and address of person who completed cause of death (Item 23a) (Type, Print) Grace Brooket 18100 Slade School Road San 31. Date filed (Month, Day, Year) State 62010 Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 22161 State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<u>010</u> Physician/ 6:45 Рм July 4 Howard Harrington, Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Country)

Carolina **Funeral** (Month, Day, Year) Days Hours 1**X** M 2 □ F Yrs Director 1950 59 Nunk Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director N/A MD Baltimore 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1804 Harford Avenue 21213 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1) Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/A5th Grade N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other trainmait. Mary L. Smallwood Howard Harrington, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1804 Harford Avenue Baltimore, MD 21213 Mary M. Williams/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery 7/14/10 Mt. Lansdowne, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Road Baltimore, MD 21206 tx an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nset and De. th Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Examiner ISWVA NERMIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 A No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 No Other: မ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After injury 1 Natural work? 5 Pending 1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At Accident Investigation completed filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar NI

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 22162 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DOUGL AC RC: SE PM HARRIC HILL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LINUERNIY MARYLAND BAUTIMORE N/A DF MED 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**X** M 2 □ F Min. (Month, Day,) Aug. 18 112-44-1398 New 54 955 York Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director N/A1X Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 1316 Homestead Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 A Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 🗌 No Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Warfare Rigger years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Hitem 27 is marked of မှ Laura Taylor unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eunice Harris/ Wife 50 Capella Ct. Rosedale, MD 21237 Baltimore, permit. Page 1.
Department of H.
Important: If item
any injure 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 7/20/10ate 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. Owings Mills, 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service Licenses ler To amo 4210 Belair Road Baltimore, MD Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ALCOHOLC CIRRHAM disease or condition Medical resulting in death) **Examiner** FAILURE LIVER Sequentially list conditions, Examine cause. Enter Underlying
Cause (Disease or iinjury Due to for selections of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death cate has been signed by the a page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed' certificate 1 Yes 2 No Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical

P.O. Records, within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Hospital or Attending

68760

Box

State Registrar

29a. Certifier

29b. Signature and title of

31. Date filed (Month, Day, Year) 32. Registrar's Signature

BOUTSTICARES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

S. GREENE ST.

RALTIMORE MD 2401

10-05265	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onald Wayne F		perger State	of Maryland	/ Departme			Mental H			0 2216
Physicia		Registrar 1. Decedent's Name (First, Middle,Las	:)				-	2. Date of Death		3. Time of Death
Aedical Exami		RONALD WAYNI	E HORNE	ERGER				July 13, 20	10	2255 hrs
		4a. Facility Name (if not institution, giv Baltimore County Detention)		City, Town, or Li Fowson	ocation of Death		4c. County of Death Baltimore Cou	inty
Funeral		Social Security Number 6. Security Number	7. A	ge (In yrs. last birth	iday)	If Under 1 Year Months Days	If Under 24Hrs	_	(MM/DD/YYYY) 9. Bir Foreig	
Director		215-92-6950 1X	M 2 F	47	Yrs.	Month's Days	Hours	09/30	/1962 co	untry) MD
à		Usual Residence of Decedent 10a. State 10b. County	_	10c. City, Town o	or Location					10d. Inside City Limits
1 10 w ar	,	MD N/Z	Δ		TIMO					1 X Yes 2 No
ɗaryland 28a-f show any t <u>at once,</u>	Director	10e. Street and Number	3	DAL		Of. Zip Code		10	g. Citizen of What Cou	ntry?
the Man or 2 tified	Pig	6822 BANK STI	REET			212	24		U.S.A	•
21215-0036 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho s event, the Medical Examiner must be notified at once	Funeral	11. Marital Status	12. Was Deceden			Decedent of Hisp specify Cuban,		pecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
r deat	뒤	1 X Never Married 2 Married		X No	1 🗆 🗸	es 2X No	enecify:		Specify: W.F.	HITE
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner	<u>\$</u>	Widowed 4 Divorced Divorced Specify or Divorced	or Dates:	mpleted) 16a. [Decedent's	Usual Occupation	on (Give kind of		16b. Kind of Business/	
72 hou n "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or		luring mos	of working life. [DO NOT use ret	ired)		
1036 Athin 7. ene. er than Medical	d L	10			E	AINTER			CONSTRUC	TION
21215-0036 July be filed within 7 Mental Hygiene. In marked other than it event, the Medica		17. Father's Name (First, Middle, Last) GEORGE ALBEI		DEDCED		18		e (First, Middle, M		
212 Jld be Menta marke	To Be	GEORGE ALBEI 19a. Informant's Name/Relationship (T		BERGER 19b	. Mailing A	ddress (Street	ANNA and Number or		NICHOLS ber, City or Town, State	, Zip Code)
O		RHONDA HORNBERG	GER/SIST						MORE, MD.	21224
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	- 1	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from S		f Dispositions of Disposition	on (Name of cem- place)	etery,	Date	20c. Location - City or	Town, State
Pages nent o		4 Donation 5 Other Specify		ST. S		SLAUS (/17/10		RE, MARYLAN
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Fundal Service Licer	see	M	LTI				JNERAL HO	
Physician	-	23a. Part I. Enter the disease, or comp	lications that cause	d the death. Do no	1700 t enter the	S. CO mode of dying, s	NKLTNG such as cardiac	ST BZ or respiratory arre	AT.TO MD est, shock, or heart	21224 Approximate Interval
/Medical		failure. List only one cause on ea	ach line. Hanging							Between Onset and Death
Examiner		Immediate Cause (Final disease a. or condition resulting in death)	Due to (or as a cons	sequence of):						
1	١	Sequentially list conditions,	Due to (or as a con:	sequence of):						
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.								
ed sait	Exar	events resulting in death) Last	Due to (or as a con:	sequence of):						
0, be executed risician and burial - transit	edical Examiner	UNPENDED	AMENDED						-	
60, atc be shysici		IF FEMALE:	23c. If yes, outco	ome of pregnancy					23d. Date of deliver	у
OX 68760 eath certificate t attending physi	jan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant a	2 at time of death		death 3	Ectopic pregn	ancy	Month	Day Year
Box 6876(e death certificate the attending phyself for use as the b	Physician/Me	1 Yes 2 No 9 Unknown		at time or death 5	Othe	r (Specify)	- 10			
that the d		Part II. Other significant conditions	contributing to dea	th but not resulting	in the und	derlying cause gi	ven in Part I.		bacco use contribute to	
S, P. nires the signed be do	ed by							1 Yes		utopsy findings available
ords, aw requir nas been s	plet							autops perfor	sy prior to	completion of cause of
Rec The Is icate h	Completed							1 Yes		es 2 No
Vital Rec ysician: The his certificate director, page	æ	25. Was case referred to medical examiner?	Hospital:	ient 2 ER/O	utpatient	189	of Death (Check Other Nursi		Residence 6 🗸 Othe	er: Scene
n of Vision Phys. After this	٠ <u>۲</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of In	jury 28b.	Fime of Inju		y at Work?	28d. Describe h	now injury occurred	
OD C tending eath. or: Af	tion	1 Natural 5 Pending	Jul 14, 2010) ^{Year)} 0000) hrs	1 Y	es 2 🗸 No	Subject han	ged self	
Division of Vital Records, P.O. teal or attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	be 28e. Place of	Injury - At home, fa	ırm, street,	factory, office bu	uilding, etc.	or Town, S		ural Route Number, City
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		(Check chil)	ian: To the best of	my knowledge, dea	ath occurre	d at the time, dat	te and place, an	d due to the caus	e(s) and manner as sta and place, and due to t	ted. he cause(s)
To th withi To th	Medical	one) 2 Medical Examine 29b. Signature and title of certifier	and manner stated	d		29c. License			29d. Date signed (Mo	
		Do Thank 11	201)			0.0.	И.E.		July 14, 2010	
		30. Name and address of person who	completed cause of	death (Item 23a)					L	
SV		Pamela E. Southall, MD	10	dical Examine	r 111	Penn Street	, Baltimore,	MD 21201		
S Regis	tate	31. Date filed (Mon pay, Year) 2	32. R gist	rer's Signature	1					
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									-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ...Month Year Tremayne Kendell Jones Jul Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1 May 21 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min 237-23-2154 Country) I.Carolina Director Yrs 976 N Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. Count filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? ıral", or items 23a o Examiner must be 3340 Elmley Avenue 21213 Funera USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1XX Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 12th Grade Collection Specialist Collection Agency permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Larry N. Jones Alfreda J. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $21\,220$ Larry Jones/ Father 9900 Tailspin Lane Apt.G Middle River, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Young Family Plot 7/17/10 4 Donation 5 Other (Specify) Warrenton, NC 21. Signature 7 Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 Dance 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Imenace Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ام ک 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has t lirector, page 2 s autopsy performed?

1 Yes 2 No 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 1 🗌 Yes ျှ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide City or Town, State) Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death TAMES **Physician** LEE OHN 2010 9:56# /Medical 4a. Facility Name (If not institution, give street and number)
4233 Jim Bowers Road 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day) **Funeral** Months Days Hours Min. †**√** M 2□ F 78 216-28-4801 Nov 1931 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventing must be notified at once. 10d. Inside City Limits 10a, State 10h. County 10c. City, Town or Location Svkesville Carrol1 MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 4233 Jim Bowers Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify. White Baltimore, Maryland 21215-0036 1 □ Yes 2 📉 No Specify ģ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction carpenter 18. Mother's Name (First, Middle, Maiden Surname)
Annie P. Gordon 17. Father's Name (First, Middle, Last) Be Joseph R. James မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1351 Becket Rd., Eldersburg, MD 21784 Linda McQuay (daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Nurial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD 7-17-10 Lake View Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paige Haug P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed and burial-tra Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 2 No 1 Tyes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident death within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20/0 30. Name and address of person who c pleted cause of death (Item 23a) (Type, Print) NVE WEST HINSTER. FREITI STO NER 31. Date filed (Month, Day, Year) 32. Registrar's Signato State Registrar

State Registrar

DHMH 17 Rev 7/2009

JAMES

SERALDINE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

eucol

32. Registrar's Signature

MENUCCI, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIA HENUCU 5601 Loch Raven Blvd . Baltimore . MD . 21234

29c. License number

RES - 00

29d. Date signed (Month, Day, Year)

07/08/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar			epartment <i>Certificate</i>	of Health and <i>of Death</i>		giene 0 1 0	22167
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Marada June Kohne					2. Date of Dear	th Day, Year	3. Time of Death
)	Examin Funeral	er	4a. Facility Name (If not institution, give s Franklin Squa 5. Social Security Number 6. Sex	are Hose	(In yrs. last birth	nday) If Under 1	Year If Under 24 Hr	8. Date of Birth	9. Birtho	MOTE place (State or Foreign
	Director		235 54 8036 1 Dusual Residence of Decedent	M 2X F 74	Υ	rs. Months [Days Hours Mir	June 11	,1936 West	Virginia
	a-f show	ctor	10a. State 10b. County Maryland Baltimore		10c. City, Town	or Location ddle Rive	r		1	0d. Inside City Limits 1 □Yes 2X No
3	23a or 28	ral Director	10e. Street and Number 7128 Oliver Beach	Rd.		10f. Zip C	ode 21220	1	0g. Citizen of What Cour	itry?
2-0036	The work in the maryland that the maryland that the maryland that then "hatural", or items 23a or 28a-f show event, it is likedical Evaning must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 A Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1		13. Was Deceder If Yes, specify 1 ☐ Yes 2X	t of Hispanic Origin? (Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
0-6121	iene. than "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation s completed) College (1-4or 5+)	(Decedent's Usual Give kind of work of life. DO NOT use HOUSEWI	done during most of wo retired)	orking	16b. Kind of Business/Ind	dustry
	s stroughts and Mental Hygie Is marked other transmission and the same	To Be Co	17. Father's Name (First, Middle, Last) Noah Rosevelt Boyce			nousewi	18. Mother's Na		Maiden Surname)	
	permit. Tages I and 2 stooled permit. Tages I and 2 stooled moortant: If item 27 Is marke any Injury or other traumatic once.		19a. Informant's Name/Relationship (Typ. Kitty Karen Vincent				itreet and Number or F n Dr. Joppa		r, City or Town, State, Zip nd 21085	Code)
more	ment of He ant: If item ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		Disposition (Name crematory or other Cemeter		Date 19,2010	20c. Location - City or To Rawlings, N	
משונ	Departr Importa any Inju		21. Signature of Funeral Service Hicense	kowske		22. Name and Bruzdzi 1407 Ol	Address of Facility nski Funer d Eastern	al Home P Avenue Es	A. Ssex, Maryla	nd 21221
	hysician /Medical		23a.Part1. Enter the disease, or complic (shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line. Due to (or as a	solic	Acid		ac or respiratory arr	est,	Approximate Interval Between Onset and Death
E	xaminer	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Seps	consequence of	, ,,,				
Do everited	ohysician and the burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of);				
00/0	ng physic as the bu	l edical	d.							
Attending Physician: The law requires that the death certificate he executed	y the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pres 5 ☐ Other (spec			23d. Date of delive Month	ery Day Year
Cuires that I	been signed by the should be detached	þ	Part II. Other significant conditions conf	tributing to death but	not resulting in t	he underlying caus	se given in Part I.		bacco use contribute to thes 2 ☑ No 3 ☐ Prot	he cause of death?
	page 2 sho	Completed						24a. Was a autops perforr 1 □Yes	sy 🖊 prior to co	opsy findings available impletion of cause of
V I LO	sertific ector,	Be	25. Was case referred to medical examiner?	espital:				eath (Check only on	ne)	
5 de	rthis and dir	<u>۲.</u>	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient		patient 3 DOA			ence 6 Other (Special	ý)
tending	ufer death. Director: After this certificate has in by the funeral director, page 2	rtification:	27. Man or or Death 1	28a. Date of Injury (Month, Day,)		ury M	Injury at Work? 1 □ Yes 2 □ No		ow injury occurred	
or At	olirect in by	틭	4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farn (Specify)	n, street, factory, o	fice	28f. Location (St City or Town	treet and Number or Rura n, State)	il Route Number,

Medical Ce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ginny French WD 9000 Frankin 31. Date filed (Month, Day, Year)

JUL 16 2010

State Registrar 29a. Certifier (Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 22168 State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death Decedent's Name (First, Middle, Last) 2 Pate of F 3 Time of Death BERT 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Randa11stown Baltimore Seasons Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1**XX**/1 2 □ F Months Days Hours Min. Feb. 12,1926 Mary land 84 216-20-6218 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Reisterstown Baltimore 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21136 1219 Nicodemus Rd. 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 🏋 🗙 No Specify: If Yes, Give Year or Dates. WW II White Specify: XX Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Sijatz Albert Kellner, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 Goldenrod Terrace, Westminster, MD 21157 Albert L. Kellner / Son 20b. Place of Disposition (Name of Dullaney) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 7/17/10 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Signature of Funeral Savice Licensee 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to for as a consequence of

Examiner Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burne.

Physician/

Medical

10a, State

MD

Director

Funeral

Completed by

Be

Examiner

Funeral

Director

ral", or items 23a or 28a-f sho Examiner must be notified at

Page 1 and 2 should be filed within 72 hours after death

permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natur any injury or other traumatic event, the Medical I

Ph sician/ Medical

Baltimore, Maryland 21215-0036

State Registrar

Medic

(Check

only one) Signatu

edical Exami	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C	
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No g Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Completed by Physician/Medical	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
Son			performed? death? 1 Yes 2 No 1 Yes 2 No
Be	25. Was case referred to medical examiner?	26. Place of Death (Check or	nly one)
일	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 Residence 6 Other (Specify)
	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 Yes 2 No	d. Describe how injury occurred
al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
1 32			

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Department of Health and Mental Hygien 2010 22169 Certificate of Death Reg. No.
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
ı	Physici		Elisabeth Kennedy July 13 2010 2:37 AM
3	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	for any staff about my staff and any	à	The Johns Hopkins Hospital Baltimore City
	Funeral		5. Social Security Number 6. Sex 1 M 2 MF 77 Yrs. 6. Sex 1 M 2 MF 77 Yrs. 7. Age (In yrs. Jast birthday) Months Days Hours Min. Months Days Hours Min. Month Days Year) May 8, 1933 9. Birthplace (State or Foreign (Month, Days, Year)) May 8, 1933 9. Birthplace (State or Foreign (Month, Days, Year)) Germany
245	Director		219-58-6983 // ITS. May 8, 1933 Germany
	ryland show	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Ba-f	Director	Maryland Harford Havre de Grace 1 Yes 2 No
	a or 2	Dir	10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2118 Sherwood Table 21078 USA
	ns 23 must	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
9	or iter	Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No No No No No No No
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	d by	3 M Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 M No Specify: Specify: White
5-("natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
12	withir ene. than re Me	omp	Elementary/Secondary (0-12) College (1-4 or 5+) 12
	be filed within tal Hygiene. d other than "event, the Mec	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ılan	uld be Aental rked ric ev	인	Willi Rink Maria Weismuller
Maryland	2 should and Men is marke aumatic e		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and lealth m 27		William R. Kennedy (son) 241 Everhard Rd. SW, N. Canton, Ohio 44709
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
崑	artmer artant: ortant:		4 Donation 5 Other (Specify) R. A. Ferris & Co. 7/14/2010 West Chester, PA 21. Signature of Funeral Service Licensee
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001
r			23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a 15chemic bowel
1	/Medical		resulting in death) Due to (or as a consequence of):
	Examiner	Ž.	Sequentially list conditions, if any, reading to harmediate the form of the consequence of): b. Curacstive heart full re- ture ty (or as a consequence of):
	ed sit	Examine	The any leading to minerolate cause. Enter Underlying Cause, Disease or injury At vial Figure 1 to 1 to 1 to 1 to 1 to 1 to 1 to 1 t
	xecut and al-trar		that initiated events resulting in death) Last Due to (or as a consequence of):
8760,	icate be executed physician and s the burial-transit	edical	d
9	tificating physical distribution of the physi		IF FEMALE:
Box	death certific e attending p ed for use as	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 1
O. B	he dea the att	ysic	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown
σ:	t t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Ġs,	w requires that been signed I should be de	d by	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	aw requ s been 2 shou	Completed	24a. Was an autopsy findings available prior to completion of cause of
æ	The lay te has bage 2	mo	Derformed? death? 1 Yes 2 No 1 Yes 2 No
Ita	sician: Th certificate irector, par	Be C	25. Was case referred to medical examiner?
of <	Physician: this certificaters	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
uc	Ing P	ion:	27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 4 Natural 5 Pending investigation 4 Natural 5 Pending (Month, Day Year) 4 Nordent investigation 5 Nordent investigation 6 Nordent Nord
Division	death death ctor: / y the	ficat	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
á	after safter Direction by the boundary of the	Certification:	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (check only (check only a detailed in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	the H nin 24 the Fu mplete	Medical	one) and manner stated.
	50 Viji	2	29b. Signature and title of certifier 29c. License number RES 000 Tuly 13 2010
	, ,	}	
	Lev		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Dharas op on 600 North Wolfe St, Baltimore, MD, 21287
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registr	ar	JUL 162010 General S. Jacks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 11 Olgerts Longins Karklins 201<u>0</u> 3:33 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea October 3, 1 '. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 Months Hours Min. 118-28-6526 85 Latvia **Director** Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Potomac Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 11301 Hawhill End 20854 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc Completed by 1 Never Married 2 X Married Yes 2 X No 72 hours after Specify: White 1 ☐ Yes 2 K No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Geological Survey Paleontologist Be **Baltimore, Maryland** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Aleksandrs Karklins Milda Bagun-Berzins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vija L. Karklins/Wife 11301 Hawhill End, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of Montgomery crematory or other place) Crematorium, Inc. 20c. Location - City or Town, State $\mathrm{July}^{\mathrm{Date}}$ 4, 1 Deurial 2 X Cremation 3 Demoval from State 2010 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Rockville, Inc. 300 West Rockville, Maryland 2085 Pumphrey Funeral Home/ Signature of Funeral Service Licenses West Montgomery Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final in farction myocardial Priysician, disease or condition resulting in death) ninutes Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Karklins, Olgerts Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 🗌 Inpatient 2 🎾 ER/Outpatient 3 🔲 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this 28b. Time of injury 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print) Medical Center Drive.

State Registrar

31. Date filed (Month, Day, Year)

9901

Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#25perME.G906,8/6/2010,WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 247 Gilbert Wilson King Jr. Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore City Baltimore 2933 Huntingdon Avenue If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Days Hours 971971965 Director Yrs 219-86-3483 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore City Baltimore 9 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2933 Huntingdon Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important; If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Customer Service Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert Wilson King Sr. Lorraine Carolyn Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Leister (sister) 2933 Huntingdon Avenue, Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic July 1210 GlenBernie MD 21. Signature of Euperal Service Licenses 22. Name and Address of Facility Medcure, Inc. 8018 Sunport Drive, Suite 205, Orlando, FL 32809 Mone 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caust on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions CERTIFICATION APPROVED BY MEDICAL EN Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ng physician and as the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 L retail deal Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital: Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending July 7,2010 1 Yes 2 No Accident Investigation I LUN KNOWNM Subject hauged self 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locat in (Street and Number or Rural Route Number, City or Town, State) 2933 Hun Fing don Ave. determined Baltimore h ome MI Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionars T. the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) are manner as estated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0000940 , 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Parkway-Baltimore, manyland 1 McClosky 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 2905 7-16-10 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 $9:10_{D}$ John A. League Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 2710 White Hall Hitchcock Road If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Ye 1937 Months Days Maryland 1 🔀 M 2 🗆 F June 12, 73 Yrs. Director 218-32-3618 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location by Funeral Director be notified 1 Yes 2 No 28a-f Ha11 White Harford Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 United States 21161 2710 Hitchcock Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in 11. Marital Status "natural", or iter edical Examiner Armed Forces? 1958-Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give 1980 Completed 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry I Hygiene.
I other than "
vent, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Steel Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental item 27 is marked other traumatic ev မ Allen Pringle Mary Joshua N. League 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Hitchcock Road, White Hall, Maryland 21161 of Health a Cecilia W. League, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot once. 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State Metro Crematorey, Inc 7/13/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 manda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ -ollicular Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 **X** No 3 Probably 4 Unknown Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? Yes 2 XNo 1 Tyes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending **X**Natural Μ 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after dea To the Funeral Director completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier ٩

State

P.O.

DHMH 17 Rev 7/2009

Registrar

600 North Wolfe Street

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Patsy Janet Lease 091 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital 5. Social Security Number 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth Age (In vrs. last birthday) **Funeral** Min. (Month, Day, Year) 01/08/1936 1 M 2 XF Maryland 213-32-2290 Director 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: If item 27 is marked other than "matural", or items 23a or 28a-f sho in portant of the most item of th 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Director Maryland Baltimore Middle River 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 728 Lannerton Road 21220 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Richard Purdy Edna Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Lease (Husband) 728 Lannerton Road, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 107/20/2010 Baltimore, Maryland 22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician di ase or conum sulting in death) ase or condition Medical Due to (or as a consequence of) **Examiner** lune cancer vounce Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been eighed by the funeral Director. Anemia l by the attending physician and stached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 1 Yes 2 No signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been signated by page 2 should by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pag 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욛 1 🗋 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0062735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blvd. Baltimore, MD 21239

Registrar DHMH 17 Rev 7/2009

State

Aparna

31. Date filed (Month, Day, Year)

Jonna

5601

MD

32. Registrar's Signature

			Please Type or Print i SMEND ITEM State of Mary AMEND ITEM	n Black In #22perFH and/Depa #19a,per	ndelible In I, G905, 77 artment of I FH, G905, rtificate of I	k. Ensure 1 1672010, v Health and 1 7728/2010	All Copies Mental Hy WS	s Are L giene	egible.	00171
	Physicia Medi		1. Decedent's Name (First, Middle, Last) Elizabeth J. Lortz		tinouto or i		2. Date of De	ath	010 ^{Year}	3. Time of Death 7:03 P M
4	Examir Funeral Director		4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center 5. Social Security Number 278-70-4364 6. Sex 1 M 2 F 6.	vrs. last birthday) S Yrs.	4b. City, Town, o Annapol If Under 1 Year Months Days		8. Date of Birl (Month, Da 8/1/19	4c. Co	ounty of Death e Aruno 9. Birth	del place (State or Foreign ujan Samar
		rector	Usual Residence of Decedent	. City, Town or Lo			10/1/19			10d. Inside City Limits 1 Yes 2 No
	ath with the	Funeral Director	10e. Street and Number 622 Cypress Rd. 11. Marital Status 12. Was Decedent Ever in	2118 133	10f. Zip Code 21146	Hispanic Origin? (Sp	pecify Ves or No-	Unite	n of What Courted State	es
9600	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No 1 ☒ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No 1 ☐ Yes, Give Year or Dates.		If Yes, specify Cuba	an, Mexican, Puerto Specify:	o Rican, etc.)		Black, White,	
21215-	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 8th College (1-4 or 5+)	(Give	O NOT use retired)	during most of worl	king		of Business In	dustry
ryland	should be filed or and Mental Hyg r is marked oth raumatic event,	To Be	17. Father's Name (First, Middle, Last) Zosimo Pinca 19a. Informant's Name/Relationship (Type, Print)	401 14-15		18. Mother's Nan Tarcia	na Jar	rito		
Baltimore, Maryland 21215-0036	e 1 and 2 sho of Health an of Health an If item 27 is rr other trau		Nory Doyle / Sister	622 (Cypress F	Rd. Sev	erna Par	ck, MD		5
Baltim	permit. Page 1 a Department of H Important: If ite any injury or ot			Metro Cre	ematory 2. Name and Addre 421 Crai	7/1 ass of Facility Kir In Hwy. S Inie, MD	9/2010 kley-Ru E	Caton ddick	sville Funera	Maryland _ 1 Home
7.	Medical Examiner urial-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any, heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	death. Do not ente						Approximate Interval Between Onset and Death
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician a completed filled in by the funeral director, page 2 should be detached for use as the burial-	Physician/Medical	resulting in death) Last Due to (or as a constitution of present in the past 12 menths? 1	egnancy Fetal death 3 [e of death 5 [Ectopic pregnand Other (specify)		23e. Did to		d. Date of delivered Month	ery Day Year ne cause of death?
Records, F	he law requires the has been signage 2 should be	Completed by	end stage renal dis	ease			24a. Was autor perfo	an 2	24b. Were auto	psy findings available mpletion of cause of
Division of Vital Records,	ng Physician: T fter this certifica ineral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year	2 ER/Outpatier 28b. Time of injury	oth 3 DOA Oth 28c. Injur	4 ∐ Nursing H ry at k?		dence 6 🗆	Other (Specify	
Division	tal or Attendi irs after death al Director: A led in by the f	al Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe			Yes 2 No	28f. Location (S City or Tow		lumber or Rurai	Route Number,
	To the Hospi within 24 hou To the Funer completed fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my kr only one) 3 Certifying Nurse Practioner: To the best of examin 29b. Signature and little of certifier	ation and/or invest	tigation, in my opini death occurred at the 29c. Licens	on, death occurred a ne time, date and pla	at the time, date a ice, and due to th	and place, an e cause(s) ar	nd due to the ca nd manner as st signed (Month,	use(s) and manner stated. ated.
J	Sta Registr		30. Name and address of person who completed cause of death (0		C		UT	114	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eliza Jane Liston 2010 14 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner Manor Care Ruxton Baltimore County Towson 8. Date of Birth (Month, Day Year) April 15,1917 Mantgamery Co.,MD. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 XF 216-07-7369 Director 93 Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 item 27 Is marked other than "natural", or items 23a or other traumatic event, the Mountal Examiner must be I 52 E. Timonium Road 21093 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 12 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be fi and Mental I Howard B. Day Mary E. Darby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is Mr. Edward Lee Girvin (Son) Lutherville, Maryland 21093 52 E.Timonium Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State (Baltimore City) 20a. Method of Disposition Date July 19, Important; If it any Injury or c 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 2010 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Reaceful Alternatives Funeral & Cremetion Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Deme days Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an has autopsy certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending Injury Natural Accident 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attent within 24 hours after death To the Funeral Director: the 3∏ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D005928 son tho completed cause of death (Item 23a) (Type, Print) Bellong Lane Hado M.D.

DHMH 17 Rev 1/2001

State Registrar

10-04950	
Andrew Lavell	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 22176

State of Maryland / Department of Health and Mental Hygiene

Andrew Laven		State Of Marylan I- For State Registrar	-	ificate of		iu Mentai		eg. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)					2. Date of Deat	th	3. Time of Death
Medical Examin	ner	Andrew Russell Lav	ell				July 1, 20	Day Year 10	2130 hrs
		4a. Facility Name (if not institution, give street and numb	er)	4	b. City, Town, o	r Location of De	eath	4c. County of De	ath
		105 F Crockett Avenue Apt. 1			Fruitland			Wicomico	
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. Ias	t birthday)	If Under 1 Year Months Day		Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. I For	Birthplace (State or eign
Director		unk 12 F	45	Yrs.	I WIOTINIS Day	75 FIOURS	09.0		Country)AZ
<u>*</u>		Usual Residence of Decedent 10a. State 10b. County	100 City T	own or Location					10d. Inside City Limits
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	William George Lave 19a. Informant's Name/Relationship (Type, Print)	<u>ell</u>	10h Mailing	Address /Chr		na Joan	Price ber, City or Town, Sta	4- 7:- 0-d-)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	٩	James Lavell/brother						San Dei	
and 2 and 2 Tealth Item 2 traur		20a. Method of Disposition		ce of Disposit	ion (Name of ce	metery,	Date	20c. Location - City	
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Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Donation 5 Other Specify: Signature of Funeral Service Licensee						i .	•
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Medical	d.	3a,pt.I	I,27,2	8a-f pe	r me g9	07 9-8-10) vt	
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Box 687 e death certific. the attending p ed for use as th	sici	4 Pregnant	at time of death	5 Othe	er (Specify)			İ	
D. B.	Physician/	Part II. Other significant conditions contributing to de	ath but not resu	ulting in the un	derlying cause o	niven in Part I	23e. Did to	bacco use contribute	to the cause of death?
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Divis pital or At ours after d eral Direc	Certification:	4 Homicide determined (Specify)	unknown	1			or Town, St unkr		
Hosp 24 ho Fune etely f		29a. Certifier 1 Certifying Physician: To the best of							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examiner and manner state		er investigatio			d at the time, date a		
	Σ	29b. Signature and title of certifier	M	γ	29c. Licens			29d. Date signed (M	lonth, Day, Year)
		MM LY	/ /	1	O.C.I	M.E.		July 2, 2010	
\mathcal{S}		80. Nar and address of person who completed cause o	·		Ponn Ct	Poltimara	MD 24204		
V		Russell Alexander MD. Assistant Med 31. Date filed (Month, Day, Year) 32. Regis	ar's Signature		Penn Street,	bailimore,			
Sta Registr		IIII 16 2010 /2	a Mada	1. 4	ares		OCME		
DHMH 17 Rev 1/20			(ORIGINAL	4.0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedept's Name (First, Middle, Last) 2. Date of Death Physician/ 2:35 Medical Town, or Location of Death 4a. Facility Name (it not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Hopkins Baynew Medical If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) unk **Funeral** June 4, 1937 Months 1 M 2 - F Director 229-34-5371 73 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🛣 Yes 2 🗌 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Funeral with 1 23a 21222 USA 2980 York Way items 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Armed Forces 2 hnk ö ģ 1 Never Married 2 Married Yes 72 hours after Specify: white Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) the Medical 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) unk Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last)unk 18. Mother's Name (First, Middle, Maiden Surname) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4940 Eastern Avenue; Baltimore, Maryland 21224 Bayview Medical Center Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state Signa ure Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Mrector Baltimore, Maryland Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a Part Approximate Interval Retween Onset and Death Immediate Cause (Final disease or condition Physician/ waunk Medical resulting in death) Due to (or as a consequence of) hemorrhade Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ed by the a detached t g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 4 Unknown 1 Yes Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 6 25 10 funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1.31 AM work? ☐ **N**atural 5 Pending pedestrian 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Nymber, City or Town, State) Dunman Wayard Yark Way Dundalk, MD, 21222 Suicide 6 Could not be ace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue, Baltimore, MD. 21224 4940

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 9,11,12,16a,6-19b per ab g905 7-26-10 vt
State of Maryland / Department of Health and Mental Hygiene amend items 15,20a-c,22 per fh g906 8-11-10 vt 17
Certificate of Death

Reg. No. For State & Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Floyd Mitchell July 2010 1:23 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 □ F 216-36-5698 Septh, Po Year 1939 Maryland 70 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tryes 2 No Baltimore 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral 21213 USA 1300 E. Lanvale Street #812 11. Marital Status - unk 12. Was Decedent Ever in U.S. Armed Forces? TITE 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation UTILE (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12)
8th unk College (1-4 or 5+) trash collector Howard Co. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unic ျှ Lemuel Mitchell F. Mitchell Lillian White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201_E. University Pkwy: Baltimore, MD 21215 19a. Informant's Name/Relationship (Type, Print)

Union Memorial Hospital
Carolyn Ward- great niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Olbura Greenmount Cemetery 7-27-10 Baltimore, Md. Signature of Puneral Service L 223Namatau AddastoffacilivBoard: 655 W. Baltimore S Chatman Harris F.H 5240 Reisterstown Rd. Baltimore, Maryland 21201 21215 Street 3a. Pa 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ hypoxia disease or condition 48 hours Medical resulting in death) Due to (or as a consequence of): Examiner 8 days Dueumo tho rax Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed terminal non small cell lung cancer Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 2 No as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has , page performed' 1 ☐ Yes 2 ☐ No Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this (4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending injury n 24 hours after death.

Funeral Director: After objected filled in by the fun 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/10/2010 AT- 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leanne East University Parkway Foster 201 Baltimore. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 20b per fh g905 7-23-10 yt State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 22179 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18:35 M Medical Examiner or Location of Death 4c. County of Death 405 Kaltimore . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** M 2 □ F Months Min (Month, Day, Director Usual Residence of Decedent 10c. City, Town or Location 29/9 Ridge Croft 10a. State 28a-f sho 10b. County items 23a or 28a-f sho ner must be notified at by Funeral Director 10d. Inside City Limits MD 1 🗌 Yes 2 X No 10e. Street and Numbe 10g. Citizen of What Country? Ridaecroti Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📈 No Il Hygiene. other than "natural", Specify 3 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) WOLK or other traumatic event, Be and 2 should be filed 17. Father's Name (First, Middle, Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve မှ itchel ones 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Page 1 (1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SQUAMOUS CELL disease or condition resulting in death) 10N745 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attei completed filled in by the funeral director, page 2 should be detached for i in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 1 🗌 Yes Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 ☐ Yes 2 XNo Other: 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 Cher (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Suicide 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Date filed (Month, Day,

DANIEUR DOBERMAN MO 6701 N CHANLES ST, SMITE 4105

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JULY 13, 2010

BALTMIRETHUS 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Ju Lette /Medical 4c. County of Death City, Town, or Location of Death **Examiner** 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Director Usual Residence o Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. My dical Examinar, ust by notified an once. 1 ☐Xes 2 ☐ No Funeral Director TIMORE 10g. Citizen of What Country? Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Completed by Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ecordary (0-12) College (1-4or 5+) ther's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ 19a. Informant's Name/Relationship (Ty Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Serv e Licensee Approximate
Interval Between
Onset and Death
How Thomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical two Houll **Examiner** ner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last nsequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 NO 1 🗆 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 1 Yes 2 No 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 5001 Loch aver 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

				e or Print in Black ate of Maryland					•	
	Physici	an	State Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death	2. Date of Dea Month July	reg. No 2 0 1 0 th Day 2010	2.2 DBh 4:50pm M
	/Medic Examir	al	Richard J. Molloy 4a. Facility Name (If not institution, give stree				r Location of Death	July	4c. County of Dea	
	Funeral Director		Lorien Nursing Centers. Social Security Number 214-22-4448	7. Age (In yrs. las	st birthday). Yrs.	Mt. Ai	rey If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 05/06	CC	thplace (State or Foreign puntry)
	e Maryland a-f show iffied at	ctor	Usual Residence of Decedent 10a. State 10b. County Md Howard		Town or Lo					10d. Inside City Limits 1 □Yes 2 No
	h with the	Funeral Director	10e. Street and Number 13751 Barberry Way			10f. Zip Code 2178	34		I0g. Citizen of What Co USA	ountry?
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		1 □ Never Married 2 □ Married 1	Vas Decedent Ever in U.S. Armed Forces? Yes 2 □ No Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cub I ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh:	te, etc.
21215-0036	thin 72 ho ie. ian "natur Medical I	Completed by		n mpleted) College (1-4or 5+)	(Give life. L		pation during most of work d) dechnician		16b. Kind of Business Sheet Meta	•
land 21	ild be filed wi lental Hygien ked other th ic event, the	To Be Con	12 Yrs. 17. Father's Name (First, Middle, Last) Francis Molloy		Silee	. Metai i		e (First, Middle,	Maiden Surname)	<u> </u>
Maryland	nd 2 shoualth and N 27 is mai r traumai		19a. Informant's Name/Relationship (Type. F Richard J. Molloy Jr	· .		-			r, City or Town, State, , Md . 21784	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ea		20a. Method of Disposition 1	cen	netery, crer	sition (Name of natory or other pla n Mausole	ce) ;	Date 1/2010	20c. Location - City or Marriottes	
Balti	permit. Departr importa any Inju		21. Signature of Funeral Service Licensee	cust mai	7764	P.O. Box	: 195 Syke	esville,	Md. 21784.	& Chapel PA
1	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition	ons mat aused the death. Buse each line. End Stage Pa:			ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death) Sequentially list conditions b	Due to (or as a conseque Aspiration P	neumo	nia				Week
	e executed ian and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque Hypertension	W/ I	schemic l	Heart Dise	ease		Yrs.
8760,	cate be ex physician the burial			Due to (or as a conseque Dementia Vas	cular					Yrs.
P.O. Box 687	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medica	in the past 12 months?	f yes, outcome pf pregnand 1□Live birth 2□Fetal d 1□Pregnant at time of dea 9□Unknown	leath 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributions Immobility S	uting to death but not result yndrome, Hype	ing in the ui rlipi	nderlying cause giv demia,Del	ven in Part I. nydration		obacco use contribute t 'es 2 □ No 3 □ F	o the cause of death? Probably 4 Unknown
Vital Records,	ding Physician: The law re n. After this certificate has bee funeral director, page 2 sho	Completed						24a. Was autop perfo 1 Yes	an 24b. Were a prior to death?	
r Vita	lysician iis certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No Hospi	ital: 1	R/Outpatier	nt 3 DOA Oth	26. Place of Deather: 4 Nursing Ho		ne) dence 6 □Other (Spe	ecify)
Division or	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification: 7	1 Natural 5 ☐ Pending 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) 8e. Place of injury - At hom	28b. Time of Injury	M 1□	ry at rk? Yes 2 □ No		now injury occurred Street and Number or F	tural Route Number,
DIA	ospital or I hours after uneral Dire		29a. Certifier 1 Certifying Physicia	building, etc. (Specify) In: To the best of my knowl On the basis of examination					cause(s) and manner a	
	To the H within 24 To the F complete	Medical	one)	and manner stated.		29c. Licens D547	se number		29d. Date signed (Mon	oth, Day, Year)
	101		30. Name and address of person who comple Allen Reilly M.D. 8	1	10 - 1 /T	B :	_	. 21701		
	Sta Registi		04 D 4 Clad (84 ath Day 16 an)	32. Registrar's Signatu						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22182 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<u>10</u> $J_u^{\frac{\text{Month}}{1y}}$ Physician/ Malkin Edythe Estelle Alpert 13 12:33 p.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 5, 1919 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖵 F Pennsylvania Director 185-05-9540 91 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 No Montgomery Silver Spring MD 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 20904 United States 13600 Stoner Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐xNo If Yes, Give Specify: White 1 Yes 2XNo Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Federal College (1-4 or 5+) Elementary/Seconday (0-12) Government Illistrator/Artist Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Brownstein Isadore Lonker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 r) 506 Copley Lane, Silver Spring, Maryland 20904 (granddaughter) Linda Gurevich 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JulyDate 18, 1 X Burial 2 Cremation 3 Removal from State 2010 Falls Church, Virginia King David Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Versice Licenses 22. Name and Address of Facility Rapp Funeral & Cremation Service 333 Gist Ave. Silver Spring, Maryland 20910 933 Gist Ave. Silver M00982 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirating arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, Large Intraventricular Bleed disease or condition resulting in death) Medical Due to (or as a consequence of), nm mn Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Pospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical ALK $I N \in D \cup THE$ Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🖾 No Dav 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrilation, Hypertension, Dementia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1xXYes 2 □ No Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes ※XNo Certificate: 28d. Describe how injury occurred 1 Natural
2 X Accident 5 Pending Trip & Fall 07/07/2010 7:00 a.M Investigation completed filled in by the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. Specify)
Assisted Living 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3700 International Dr., Silver Sping, MD 20906 determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for the cause of t (Check within 2 To the F only one 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) July 14, 2010 address of person who completed cause of death (Item 23a) (Type, Print) M.D. 5530 Wisconsin Ave. Chevy Chase, MD 20815 Jeffrey Muench, 32. Registra's Sig

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e perFH, G905, 7/16/2010, WS#31perDVR
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 6:15 AM Pacu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 602 Churchill Rd. Unit Ε. Harford Air ar If Under 24 Hrs. ys Hours Min. Bel Social Security Numbe . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Months Days May 24, Maryland 65 216-42-1687 1945 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 1 No Harford MD Bel Air 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21014 United States 602 Churchill Road Unit E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Specify. White 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Health Admin. Assistant 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important. If item 27 is marked oth any injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Marie Malczewski Vincent Havlicek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Little /Daughter 2905 Byron Court Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ^{Date}Jul 1€ 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 2010 4 ☐ Donation 5 ★ Other (Specify) 22. Nan@rethatesom Facility Funeral Alternatives Signature of Funeral Service Licensee Molyga 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final xones-Physician/ 0 disease or condition Medical resulting in death) **Examiner** 28/10/de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner sequence of to (or as a c Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 3 ☐ Probably 4 ☐ Unknown 1 Yes After this certificate has been 24b. Were autopsy findings available 24a. Was an prior to completion death? autopsy completed filled in by the funeral director, page 2 performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury work? 1, Natural 5 Pending 2 🗆 No 2 Accident Investigation within 24 hours after deat To the Funeral Director, 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 🗌 3 🔲 (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature angettle of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) D (OUN 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Cynthia D. Newcott 2010 July 11 7:45 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5512 Massachusetts Avenue Bethesda Montgomery Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Hours Min Days 136-52-1916 56 June 30, 1954 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 TYes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5512 Massachusetts Avenue United States 20816 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donald E. Kanaley Phyllis J. Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Newcott/Spouse 5512 Massachusetts Avenue, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, crematory or other place)
Park Lawn
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition July Tate 7. 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 Luf. M01498 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 years disease or condition resulting in death) Ovarian Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🐼 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Tes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1x Natural 5 Pending Injury investigation 1 □Yes 2 □No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

July 12, 2010

/Medical Examiner requires that the death certificate be executed burialphysician the attending p as the signed by 1 be detach cate has I page 2 s

Examiner Physician/Medical ģ Completed certificate director, Be this Medical Certification: To funeral c After

Physician

/Medical

Examiner

Funeral

Director

show

28a-f

23a or

Items

"natural", or

marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event.

Physician

filed within Hygiene.

within 72 hours after death with the

Baltimore, Maryland 21215-0036

Director

Funeral

\$

Completed

Be

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traumatic event, the Medical Evaniment aust be notified at

Division of Vital Records, P.O. Box 68760, Physician: Hospital or Attending after death

Director: A in by the f filled in I e Funeral hours

State Registrar

MDBruce Kressel. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

5530 Wisconsin Avenue, Chevy Chase, Maryland 20815 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0023600

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10b per the 905 7-16-10 yr. State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:08 PM li aus Han pton 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Raven Baltinors If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1/30/ Country) Director DC or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Carrol1 Director 1 🗆 Yes 2 XNo MD Frederick Mount Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral US<u>A</u> 6607 Runkles Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1943 Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mea Construction Elementary/Seconday (0-12) College (1-4 or 5+) Masonary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Hamiton Oliff Nellie Viola MacWelch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Giebel/Daughter 1250 Delaware Ave. Churchtown, MD 20733 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Jul 13. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Chesapeake Crem. 2010 Beltsville. 22. Name and Address of Facil CAFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licenses 8717 Green Pastures Dr. Balto, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final warrous Cell Carcinoma Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day 1 Yes 2 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autonsy 2 🗌 No this certificate 1 Yes 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 1 No ၉ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manyner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director. After completed filled in by the funer injury 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and time of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21218 Boulevard, In.D. 31. Date filed (Month, Day, Year) Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ^{Day} 2<u>010</u> Month Rachel A. O'Hern 13 July 4b. City. Town, or Location of Death 4c. County of Death Montgomery Rockville 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Months Days Min 1 □ M 2 🕱 F Hours Vre

For State Registrar 22186 1. Decedent's Name (First, Middle, Last) Physician/ 6:20 A Medical 4a. Facility Name (if not institution, give street and number **Examiner** Montgomery Hospice Casey House 5. Social Security Number 8. Date of Birth (Month, Day, Ye August 29, g. Birthplace (State or Foreign Country) West Virginia **Funeral** Year) 1<u>923</u> 285-20-3506 Director 86 Usual Residence of Decedent shov 10a. State death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 5 10f. Zip Code Examiner must be 23a Funeral 13119 Ardennes Avenue 20851 United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 X Widowed 4 □ Divorced Completed Year or Dates. Korea the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Sears of Health and Mental Hygi item 27 is marked other other traumatic event, it Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Heath and Mental I-Important: If item 27 is marked or any injury or other traumatic ever ျ Francis M. Brown Dollie Covey 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Marie O'Hern:/Daughter 13119 Ardennes Avenue, Rockville, Maryland 20851 20b. Place of Disposition (Name of 20a. Method of Disposition Cemetery, crematory or other place)
Montgomery
Crematory 20c. Location - City or Town, State July 16, 1 Durial 2 X Cremation 3 Removal from State 2010 Bethesda, Maryland 4 Donation 5 Other (Specify) remători um. Name and Address of Eacility Robert A. Pumphrey Funeral Home/OCKVIIIe; Inc. 300 West Montgomery Avenue 21. Signature of Funeral Service Licensee 22. Name and Address Rockville, Rockville, M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Aspiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, iner if any, leading to immediate cause. Enter Underlying Cause (Disease of initially that initiated events Due to (or as a consequence of): sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Sepsis page 2 should been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Acute RenalFailure has autopsy performed? this certificate 1 Yes 2 No Yes 2X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospice Inpatient Hospital Other: 2 🔀 No 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🏝 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) R120698 July 13, 2010 200gr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nichole Christenson CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20855

State Registrar 31. Date filed (Month,

32. Registre 's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #14 State of Maryland Poeparthen 996Hearth and Muntal Hygiene 0 | 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8:00AM Medical Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death Randalls Town 4c. County of Death Examiner Jenesis Randallstour Baltimor Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 5. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc Black 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam ဂ္ Riley Pinkston Hannah 19a. In Robert me Welatic Ship Type 7 intephev 195 Maithe Addres (Erregiand Number or Evel Route Number, City 10103), State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or otherplace 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) neral Service License 23a. Part 1. Enter the disease, or complications that caused the death-Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ma 2/21 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached for 1 ∐ Yes 2 L 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical examiner? **Division of Vital** Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2V No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural To the Hospital or Attending within 24 hours after death.

To the Funeral Director, Afte completed filled in by the fun 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RU841 7-14-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown, MD 9109 Liberty Road CRMP

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day Physician/ 2010 5:15 Рм Frederick C. Petrich 14 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 11940 Bel Air Road Kingsville If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 1 XM 2 □ F . Age (In yrs, last birthday) **Funeral** April 10,1926 Maryland 84 214-34-3388 Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at Director 1 Yes 2 XNo Kingsville Baltimore Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21087 11940 Bel Air Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. IX Yes 2 No 1950 f Yes, Give Page 1 and 2 should be filed within 72 hours after d ment of Health and Mental Hyglene.

The strip is marked other than "natural", or i and the strain and or other traumatic event, the Medical Examin ury or other traumatic event, the Medical Examin Completed by 1 X Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 🗆 Divorced 1952 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Self Employed Voice Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederich C. Petrich Catherine Reuter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6301 North Charles St. Apt. 101 Baltimore, MD 21212 Phyllis Burg, P.O.A. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date Department of Important; If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 07/16/10 Baltimore, Maryland Signature of Funeral Service License Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardionyopathy
Due to (or as a consequence of): Physician 10 upars disease or condition Medical resulting in death) Examiner isease 30 years ronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a cor sequence of): Exami attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death I signed by the a Yes 2 No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ heart 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has I autopsy death? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 🔼 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Muhail Norman Biosener M.D. D32288 July 15, 2010

Registrar

State

30. Name and address of person who completed cause of death litem 23a) (19pe, Print)
Michael Norman Drossner, M.D. 520 Upper Chesapeake Dr. Bel Air, Maryland 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 15:07 PM Albert J. Perry, III 200 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year North, Day, Year Peb. 8, 1948) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 ☐ F Mary land 215-50-8027 62 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show 1 XYes 2 □ No Director Baltimore Md. n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21210 USA 12 Roland Mews Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 X No Specify. other traumatic event, If a Medical Exaþ Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) is marked other than Financial President/Owner 18. Mother's Name (First, Middle, Maiden Surname) land 17. Father's Name (First, Middle, Last) Be Mary Galbraith Albert J. Perry, Jr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 536 Mulberry Ln. Haverford, Pa. 19041 Mr. Peter Burgum/ Brother in Law Department of Heal Important: If item 2 any Injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 Removal from State Hillton Service Co. 7-16-10 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility on Funeral Home, Inc. 21. Signature of Funeral/Service Licensee 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LEFT LUNG EUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ADENOCARCINOMA for use as the burial-tran the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by STENOSIS 3 Probably 4 Unknown 1 ∏Yes 2 ∏ No certificate has been PANCREATITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed & DNo 1 □Yes a.DNo 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient After this of 2 ER/Outpatient 3 DOA Medical Certification; To 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending nours after death.

neral Director: A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 2010 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANSA 5601 Loch Raven Boulevard, Baltimore Maryland 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Mi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f any Injury or other traumatic event, it e Medical Exemiter must be notified.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit

Division of Vital Records, P.O. Box 68760, Sta Registr

	1 - State Of Walls		ertificate of L			g. No.	22190
an	1. Decedent's Name (First, Middle, Last) Ruth Lois Richardsor	1			2. Date of Death	1, 2010 Year	3. Time of Death 7:00am м
cal ner	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	
	Transitions Health Care Cer 5. Social Security Number 6. Sex 7. Age (/	nter in yrs. last birthdi	ay) If Under 1 Year	sville If Under 24 Hrs.	8. Date of Birth (Month, Day, May 4,	Gar 9. Bi	roll rthplace (State or Foreign
	214-32-4157 1□M 2XPF 89	Yrs	Months Days	Hours Min.	May 4, 1	921	MD MD
	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town or	Location				10d. Inside City Limits
ctor	MD Carroll		Sykes	ville			1 X Yes 2 No
ral Dire	10e. Street and Number 7309 Second Avenue		10f. Zip Code	21784	10	g. Citizen of What C	ountry? USA
Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Was Decedent Eve Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	r in U.S. 1	3. Was Decedent of Hilf Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
letec	15. Decedent's Education (Specify only highest grade completed)	16a. De	ecedent's Usual Occup ive kind of work done o e. DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business	s/Industry
Į MO	Elementary/Secondary (0-12) College (1-4or 5+)	I .	Dietary Sup			State of	Maryland
Be	17. Father's Name (First, Middle, Last)				_{e (First, Middle, M} lva Lynch		6
은	Edward Pickett 19a. Informant's Name/Relationship (Type. Print) (Daugh:	ter) 19b. M	ailing Address (Street a				Zip Code)
	Mrs. Darlene R. Richardson	720)1 Violet C				
	20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dis cemetery, c Springfi	sposition (Name of crematory or other place Le1d Cemete	ery 7/14	I .	oc. Location - City o Sykesvill	
	21. Signature of Funeral Service Licensee Sua A Haist Mo	0764	22. Name and Addres	ss of Facility HA 195 Syke	IGHT FUNI sville, N	ERAL HOME ID 21784	& CHAPEL, PA
	23a. Part 1. Enter the disease, or complicates that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	entia	enter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
-	Due to (or as a co						
amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a created cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a created cause.)	orisequence or).					
edical Examiner	resulting in death) Last Due to (or as a co	onsequence of):					
	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐		3 ☐ Ectopic pregnance	u .	***	23d. Date of d	
hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		5 Other (specify)			Month	Day Year
d by P	Part II. Other significant conditions contributing to death but n	ot resulting in th	e underlying cause give	en in Part I.	23e. Did tob	_/	to the cause of death? Probably 4 ☐ Unknown
Be Completed by Physician/M					24a. Was an autopsy perform	prior to death?	autopsy findings available occompletion of cause of
	25. Was case referred to medical examiner? Hospital: Hospital:		time of Box Other		th (Check only one		
n: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpa 28b. Tim	e of 28c. Injur	4 Mursing H	ome 5 Resider 28d. Describe hor	nce 6 ☐ Other (Sp w injury occurred	pecify)
catio	1 Natural 5 Pending (Month, Day, You investigation 3 Suicide 6 Could not be	ear) Inju		(? Yes 2 □ No			
Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, Specify)	street, factory, office		28f. Location (Str City or Town	eet and Number or I State)	Rural Route Number,
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of manual manner stated and manner stated	amination and/o	eath occurred at the tire investigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	tuse(s) and manner ate and place, and de	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier Will 44 M1)	29c. Licens			7/12/16	nth, Day, Year)
	30. Name and address of person who completed cause of deat Wilbur Kue 295 Sta	h (Item 23a) (Ty	Are St	307 0	ivestorin	ste M	10 21157
te ar	31. Date filed (Month, Day, Year) JUL 16 2010 Server 8.	Signature	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 14, 2010 Physician/ July Charles Robert Riegger, Sr. 2:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 200 Hazelnut Court Air 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. February 1 X M 2 - F Months Days Hours Mary land 217-26-3750 Director 78 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Hazelnut Court Apt. D 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 🗶 No Specify. White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Technician C & P Telephone Co. 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Christian A. Riegger Etta Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stephen H. Riegger, Sr. (Soln) 101 Tenbury Road Lutherville, Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Druid Ridge Cemetery! 7/26/2010 Pikesville Maryland 21. Signature of Juneral 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Min VTES→#RS Immediate Cause (Final Ph sician/ +cuTe disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ears Samuar tially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a ears sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sleep 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

Registrar

aurene

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Has

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month Year Physician KICHARDSON / AM 2010 14/ 10 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Social Security Number 9. Birthplace (State or Foreign Country) Date of Birth (Month, Pay, Age (In yrs. last birthday) Sex 1 X M 2 ☐ F **Funeral** 219.40.1701 Months Days Hours 6 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10d. Inside City Limits show 10c. City, Town or Location Injury or other traumatic event, the Medical Examinar must be notified at BALTIMORE Director MD 1 X Yes 2 □ No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 3455 CottAge AVE 21215 USA 23a Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Nes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: SLC permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatin averal. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COOK 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HELEN FLOXD CLARENCE KICHARDSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tall LANIER AVE. BALTIO, MD. ZIZIS GILDERT KICHARDSON/BROW 20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CLEMATORY 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BACTIO, NID 22. Name and Address of Facility Thulips turing Name 21. Signature of Funeral Service Licensee Thectr CFSPICAC 1721-27 N. MONROE ST. BALTIMORE, MI) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician of Chronic Obstructive Lune Diseas Dm0 /Medical Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of): ng physician a P.O. Box 68760 Completed by Physician/Medical attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No signed by the a 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 □ Yes 2 No of Vital Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year)

State Registrar (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			T State of Ma	aryland / Depa <i>Cer</i>	artment of He	alth and M ath	ental Hygie	ene 2010	22193		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Eunice Savage				2. Date of Death Month	Day Year	3. Time of Death		
****	Medic Examin	cal	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	July	14 2010 4c. County of Deat	6:15AM		
-) Examin		Seasons Hospice		Randallst			Baltimo			
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 □ M 2 🕅 F	(In yrs. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You 11_19_191	ear) Co	thplace (State or Foreign untry) M		
	d Now It	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		11-17-171		10d. Inside City Limits		
	farylan Ba-f sh tified a	Director	MD n/a	**	imore				Y Yes 2 ☐ No		
	th the N 3a or 2 the no	al Dii	10e. Street and Number 701 N. Arlington Avenue		10f. Zip Code 21217		10	g. Citizen of What Co	untry?		
	eath wire	Funeral	11. Marital Status 12. Was Decedent Ev		Vas Decedent of Hispa	anic Origin? (Spec	ify Yes or No-	14. Race - Ame	rican Indian,		
36	after de al", or it xamine	þ	1 Never Married 2 Married Armed Forces? 1 Yes 2 If Yes, Give If Yes, Give Year or Dates	No O	f Yes, specify Cuban, I ☐ Yes 2 👿 No		ilican, etc.)	Black, White Specify: Afr	e, etc. Ican-American		
2-00	hours 'natura'	olete	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupation		10	6b. Kind of Business			
121	ithin 72 ene. r than ' the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5+	life D	O NOT use retired)	ng most or workin	9	Factory			
Baltimore, Maryland 21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Charles Savage		18	8. Mother's Name Mammie H	(First, Middle, Ma				
ary	should and Me is marl		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and	l Number or Rural	Route Number, C	ity or Town, State, Zip	Code)		
e,	and 2 s Health em 27		Brenda M. Forrest/Niece 20a. Method of Disposition	21 20b. Place of Dispo	Tentmill Land			e, MD 21208 Dc. Location - City or	Town State		
mor	Page 1 nent of ant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cren	matory or other place) morial Park	7 - 23-		rbutus, MD	Town, Otato		
Balt	permit. Departr Imports any inju		21. Si nat re of Funeral Service Licensee	1 22		of Facility Wyli	e Funeral 1	Home P.A. of	A. of Balto. Co.		
	111		23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.		Approximate Interval Between						
	Pnysician/ Medical	8 9	reculting in death)	the Brain	Canier				Onset and Death		
	Examiner	<u>.</u>	Sequentially list conditions.								
	ted Insit	Examiner	if arry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	ฉับกลัยนุปอกจัย บร้า.							
	e execuian and	al Exc	that initiated events c. Pue to (or as a	consequence of):					-		
200	cate be physics the bu	edical	d								
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live Birth 2 1 □ Live Birth 2 1 □ Res 2 ☑ No 9 □ Unknown	2 🗌 Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year		
P.O.	that the ned by the detach	by Phy	9 Unknown Part II. Other significant conditions contributing to death bu	ut not resulting in the u	nderlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?		
ds,	equires sen sign ould be	ted k					1 🗆 Yes		robably 4 Unknown		
Division of Vital Records, P.O.	or Attending Physician: The law re affer deactor. Director. After this certificate has bo line by the funeral director, page 2 st	Completed					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of		
ital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			e of Death (Check		ce 6 Other Spec	ent hospice		
of <	ng Phys fter this ineral di	ate: To	27. Manner of Death 1 ✓ Natural 5 ☐ Pending (Month, Day,	nt 2 ER/Outpatien y 28b. Time of Year) injury	28c. Injury at		ne 5 LI Residene 8d. Describe how		ity)		
sion	Attendir death.	Certificate:	2 Accident Investigation	ry - At home, farm, stre		s 2 🗆 No	8f. Location (Stre	et and Number or Ru	ral Route Number,		
Σ̈́	ital or uns after ral Dire		building, etc.				City or Town, S	State)			
3	To the Hospital or within 24 hours afti to the Funeral Dir completed filled in	Medical	29a. Certifier 1 Certifying Physician: To the best of n (Check 2 Medical Examiner: On the basis of examiner) Only one) 3 Certifying Nurse Practioner: To the basis of examiners on the basis of examiners.	amination and/or invest	igation, in my opinion,	death occurred at t	the time, date and	place, and due to the	cause(s) and manner stated.		
1	To the Control of the		29b. Signature and title of certifier NSRYWPWWMMD		29c. License nu	57467		d. Date signed (Month	2		
	31		30. Name and address of person who completed cause of de N - S・RynpのKK , M・D 283	ath (Item 23a) (Type, P	rint) - 8-235-	Baltin	ione, MD	1.21200	1		
	Stat Registra		31. Date filed (Month, Day, Year)								

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Hre			For State Registrar		se Type or Price of Litems 2	arviand TEM/28a	Depa Per Cert	ME, G906 ificate of L	Tealth and 1 8/17/201 Death	Mental Hy	/gien Reg. N	e2010	22194
5	Physicia	an/	1. Decedent's Name	e (First, Middle, L	ast)					2. Date of De July			3. Time of Death
5	Medic	cal		NE GRACE not institution, g	ive street and number)			4b. City, Town, or	Location of Death			c. County of Dea	
-	,		Gilchrist (Towson				Baltimor	
0	Funeral Director		5. Social Security No. 104–10–1551	1	Sex 7. Ag	e (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di June 9.1	rth av, Year) 91 6	g. Bir Co New	rthplace (State or Foreign ountry) VOYK
20	land show	tor	Usual Residence of 10a. State	10b. County		10c. City, Tow	n or Loca	tion					10d. Inside City Limits
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7	with th	Funeral Director	107 Kenilwo		Drive #3B			10f. Zip Code 21204			10g. C	Citizen of What Co	ountry?
13	death ritems ner mu		11. Marital Status		12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. W		ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - Ame Black, Whit	
036	rs after ural", o	ed by	1 ☐ Never Marri 3XX Widowed		1 ∐ Yes 2 XX If Yes, Give Year or Dates.	No	1	☐ Yes 2 XX No	Specify:			Specific	White
15-0	72 hou natu	Completed	(Spe	15. Decedent's cify only highest	s Education grade completed)	16a.	(Give ki	nt's Usual Occup	ation during most of work	ing	16b. l	Kind of Business	Industry
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Mand	d be filed Mental Hy arked oth itic event	To Be	17. Father's Name (I Ambrose Swe		t)				18. Mother's Nam Louise Er		, Maider	n Surname)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Robert Saut		(Type, Print) Son	362	o. Mailing 29 Hi	Address (Street a	and Number or Rur k Place Gre	el Route Numbe enville,	er, City c Nort	or Town, State, Zi th Carolin	ip Code) na 27858
Con	ge 1 ar nt of He :: If item or oth			☐ Cremation 3	☐ Removal from State	cemete	ry, crema	tion (Name of tory or other plac		Date	l	Location - City or	
altin	mit. Pa bartme bortani / injury		4/Li Donation 21. Sign ture of Fur	5 Other (Spe	ecify)	Moreland		Orial Park Name and Addres	JULY Ss of Facility Mit(timore, Ma Id Funeral	
b a	permi Depar Impo any ir	1 11	Nune	o XV VY	skonyer	iarres	6	500 York R	oad Baltimo	ore, Mary	land		
3			23a. Part 1. Enter the shock, or hear Immediate Cause (I	rt failure, List only	omplications that caused one cause on each line	d the death. Do r e. _\			g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
18	Medical Examiner		disease or condition resulting in death)		a. Due to (or is	consequence		m12					
7	Examiner	ē	Sequentially list con if any, leading to im	nditions,	b. Due to (or as	a consequence o	nfi:						
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3	an =		resulting in death) L		·	a consequence o	of):						
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a B	hysician: The law r his certificate has b I director, page 2 sl	Be င်	25. Was case referre	ed to medical				26. Pl	ace of Death (Chec	perf 1 ☐ Yes k only one)	2	No 1 ☐ Ye	s 2 No
Ž	Physic this ce	욘		No	28a Date of inju	ent 2 ER/Ou	utpatient	3 DOA Othe	4 ☐ Nursing Ho			6 Other (Spec	Gify) HOSPICE
o uo	ending eath. or: After he fune	ficate	1 Natural 2 Accident	5 Pending Investigat	ion Month, Day	v, Year) i	njury Knew	work	?		to e	xtreme en	vironmental G temperatures
$\mathcal{AF}_{\mathcal{G}}$ Division of Vital Records,	al or Attending Phy s after death. al Director: After this ed in by the funeral c	Certificate:	3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	De 200 Pla of ni	ury - At home, fa		t, factory, office		28f. Location (City or Tous B Tows	Street ar wn, State	nd Number of Ru e) 107 Ker MD	ral Boute Number, Pk Dr
_	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the by	Medical		Medical Exa	nysician: To the best of miner: On the basis of e urse Practioner: To the	my knowledge, oxamination and/o	death oc	cured at the time, ation, in my opinio	n, death occurred a	t the time, date	and plac	e, and due to the	cause(s) and manner stated.
	To the virth Com		29b. Signature and t	title of certifier	The state of			29c. License	number		29d. Da	ate signed (Mont	h, Day, Year)
	T _i		30 Name and addre	ess of person who	completed cause of d	eath (Item 23a) (Type, Pri	1718	lele /		Su	114	2010
	Cher		31. Date filed (Month	Day, Year)	tello M	D lo Tv	im	Hall;	MCTIL	nther;	١), د	6 Md	21093
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZOAM na Medical 4a. Facility Name (if not institution, give street Northwest Hospital 4c. Country Reath **Examiner** Social Security Number 214–46–1212 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 X F Months Days Hours Min. Country) (M27/187/45°ar) Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10d. Inside City Limits event, the Medical Examiner must be notified at 10c. City. Town or Location Director MD N/ABrooklyn 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3543 6th Street 21225 USA permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked Advisory or Advisory or Advisory. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Day Care Operator Child Care Be 18. Mother's Name (First, Middle, Maiden Surname)
Tillie Quinton 17. Father's Name (First, Middle, Last)
Unk. ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3543 6th Street, Brooklyn MD 21225 Lindsey A. McGrath/Grandchild 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Ardent Crematory or other place) 7/2/2010 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Victor P. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore MD Doda, Jr 22.)LU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final er Physician/ Medical resulting in death) Due to (or as a consequent e of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: ၉ 1 Tes 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month Day, work? 5 Pending 2 🗆 No Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAM LANTZ SCOTT, III JULY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TOWSON BALTIMORE GILCHRIST CENTER Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours (Month, Day, Year 1/19/1935 Director 218-32-9346 75 MARYLAND Usual Residence of Decedent or 28a-f show 10a State 10c. City. Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No ME BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21239 1120 ARRAN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: 3 X Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Mental Hygiene. arked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12TH GRADE AUTO PARTS TECH. RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ IDA CARR WILLIAM L. SCOTT, JR. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a STEWARTSTOWN, PA WILLIAM R. SCOTT/SON 902 CRESTVIEW LANE Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State METRO CREMATORY, INC. 7/16/2010 CATONSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MOO21 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MD 21286 8521 LOCH RAVEN BLVD. TOWSON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown the page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed?

Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No 1 Tyes မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer work? iniury X Natural 5 Pending ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifie 1/🖰-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of pe

31. Date filed (Month, Day, Year)

SWITE 4105 BATTMOREIND 21204

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

EMAN, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 15 July Gloria Gertrude Seidel 2010 /Medical 4a. Facility Name (If not Institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Franklin 5. Social Security Number osedale are Cerrier 8. Date of Birth (Month, Day, Year)

Jan.12,1928 Birthplace (State or Foreign Country) Age (In vrs. last birthday If Under 1 **Funeral** Min 1 □ M 2 🕱 F 82 Maryland 217 20 6984 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 1∩a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the World Event in a tast by nathed at 1 ☐ Yes 2 X No Baltimore Director Maryland Essex 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21221 USA 336 Sassafras Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 Specify: White 1 ☐ Yes 2 🗷 No Specify: 2 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important; if item 27 is marked other the any injury or other traumatic event, 1 is once. Housewife Own Home Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk. Pfeifer ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3725 Roland Avenue Baltimore, Maryland 21211 Irvin Charles Seidel Jr. (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 Removal from State Bayview Crematory Inc. 7/16/2010 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. Funeral Service Licenses 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** colon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔽 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 063054 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A FRANKLIN SQUARE DRIVE, BALTIMORE, MD, 9000

State Registrar

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32. Regultrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 15, Physician/ 2010 1:25 A.M Michael Eugene Seipp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Dove House 8. Date of Birth (Month, Day, Year) Aug. 3, 1949 Sex 1XXM 2 □ F 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days Hours Min. Maryland 60 Director 218-54-2233 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2XX No Hampstead Carroll Maryland 10f. Zip Code ō 10e Street and Number 10g. Citizen of What Country's United States ral", or items 23a or Examiner must be Funeral 21074 2439 Fairmount Road, Lot 24 America death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married XX Married þ Maryland 21215-0036 within 72 hours after 1 Yes XX No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12th Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Pauline Davidson permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic John Wilbur Seipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2439 Fairmount Road, Lot 24, Hampstead, MD 21074 Sharon L. Seipp (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State July 20 cemetery, crematory or other place, XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem'l Grdns Finksburg, Maryland 2010 Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3296 Charmil Drive, Manchester, Maryland 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MEMSMAC NEW SMAllcell CARGAGAA Onset and Death Immediate Cause (Final Physician/ 6 MONTH disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events y physician and is the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has to completed filled in by the funeral director, page 2 sl autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOOF-2 🖺 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe

State Registrar 31. Date filed (Month, Day, Year)

HOMAS K

32. Registrar's Signature

CALVY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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17/15/2010

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	F 1000		State Registrar			e of Death_	Reg. N	711111 77144
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	M. Some	2 V (UE		2. Date of Death Month	Day Year 0 0 21 M
1	Examin	er	4a. Facility Name (if not institution, give str HOSPice of - 5. Social Security Number 6. Sex	the Chesape	rake A	Town, or Location of Death napolis 1 Year If Under 24 Hrs.	9 Date of Birth	Anne Arundel 9. Birthplace (State or Foreign
	Funeral Director	ě		M 2/2 F 80	Yrs. Months	Days Hours Min.	Month Day, Year	930 Country) M.D
	faryland 8a-f shov iffied at	Director	10a. State 10b. County	10c. City, To	own or Location 2/+imo	re		10d. Inside City Limits 1 ✓ Yes 2 □ No
	with the N 23a or 2 ist be no	eral Dir	10e. Street and Number 2317 Edmonds	ion Avenue	10f. Zip		10g. (Citizen of What Country?
920	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The strand Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates.	If Yes, spe	dent of Hispanic Origin? (Spirify Cuban, Mexican, Puerto 2 No Specify:	pecify Yes or No- po Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	nin 72 hour ne. han "natur e Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	cation 1	6a. Decedent's Usu (Give kind of wo life. DO NOT use	rk done during most of wor	king 16b.	Kind of Business Industry
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	le 1 and 2 s t of Health If item 27 or other tra		Yernell Hutchins 20a. Method of Disposition	s(Daughter)	867 Ma e of Disposition (Nar	net Way	Severn M	Location - City or Town, State
Baltimore,	0 4		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		etery, crematory or o	ther place)	2/-10 A	chutus MD
altii	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee		VANAGE A	d Address of Facility	Funeral S	Services,
<u> </u>	9 9 E 8 9	. 1	laughw C. >	Tiene	5151	Baltimore N	at 1 Pike	(21229)
F	nysician/	W 9	23a. Part 1. Ent the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	o not enter the mod	e of dying, such as cardiac	or respiratory arrest,	Approximate Interval Betwaen Observanci Velyin
)	Medical Examiner		resulting in death) a.	Due to (or as a consequence	ce of):			// V * : // /
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	executed ian and irial-transit	Examiner	cause, Enter Underlying Cause (Disease or impury that initiated events					
	oe exec ician ar burial-t	l - □	resulting in death) Last	Due to (or as a consequence	ce of):			
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. Box 68	nospital or Attending Prystician: The law requires that the death certificate be a Valours affect death. Funeral Director: Affer this certificate has been signed by the attending physicial affect in by the funeral director, page 2 should be detached for use as the burning that the funeral director.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown				23d. Date of delivery Month Day Year
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on	ending eath. or: Afte the fun	ficat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury M	work? 1 Yes 2 No		House
Division	or nospiral or Arcending Prysician: within 2 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	l Certificate:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factor	, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	Funer Funer eted fill	Medical	(Check 2 Medical Examine	an: To the best of my knowledg	d/or investigation, in	my opinion, death occurred	at the time, date and pla	ce, and due to the cause(s) and manner stated.
	vithin To the compl	Σ	only one) 3 L Certifying Nurse I	Practioner: To the best of my kn		License number		Date signed (Month, Day, Year)
	10 1		JAM J Z	zen aw	a) (Time Print)	0 214	38 /	4/4 20/0
	DV		30 Name and address of person who con Office A A C	GRENTA M	1) (Type, Print) 1) 44 F	DEFEN	SEHIGH	WAY ANNAPULISMALI
	Stat Registra		JUL 162010 L	32. Registrar's Signature	200			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7/4/2010 Lois B. **Physician** Turner 4:15pm^M /Medical 4a. Facility Name (If not institution, give street and number) Collingswood Nursing Home 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville MD Montgomery 9. Birthplace (State or Foreign Country) Social Securify Number 230–16–9715 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/15/1918 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 92 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State MD Montgomery Rockville X□Yes 2□No Director 10e. Street and Number 299 Hurley Rd 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be r 20850 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Mydical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Yes 2 🗷 🕏 Baltimore, Maryland 21215-0036 white Specify: Specify: <u></u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert C. Baggette Hannah E. Ridgeway 2 19a. Informant's Name/Relationship (Type. Print) Elizabeth Faye Turner Darling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17003 Hillard St. Daughter Poolesville MD 20837 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Manning Cemetery 1 ☐ Burial 2 ☐ Cremation ★ Removal from State 7/9/10 Manning, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Victor P. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Due to (or as a consequence of) physician Completed by Physician/Medical as the l attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an certificate has t irector, page 2 s autopsy or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗆 Yes 2 No 1 🗌 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident within 24 hours after death To the Funeral Director; A 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 📉 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

Vd

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATYAD 32. Registrar's S D0062435

29d. Date signed (Mgnth, Day, Year)

Malecular Q. Rockuille, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 22201 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Nancy Lee Tavenner Year TULY 1.45PM 2010 a. Facility Name (If not institution, give street and number) ogation of Death 4c. County of Death Agnes amore 11/95 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Sept 7 1 □ M 2 □ XF ^{Year)} 1938 Months Days Hours Min 212-36-5237 71 Sept Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Carroll **Eldersburg** 1 ☐ Yes 2 🕅 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21784 USA 1308 Woodridge Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🏋 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) London Fog mailroom clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Claus James Frank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward C. Tavenner Jr. (spouse) 1308 Woodrige Ln., Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wards Chapel UMC Cem 7-17-10 Marriottsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Haight Funeral Nome & Chapel 21. Signature of Funeral Service Licensee Dauge Haught P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Odan Due to (or as a con equence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify). 9 Unknown Part JJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 □Yes 1 ☐ Yes 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2V No 2 ER/Outpatient 3 DOA

Physician /Medical Examiner Examiner

permit. Pages Department of Important: If it any injury or o

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Eventinal must be notified at

Baltimore, Maryland 21215-0036

p burial the attending physician for use as the detached ned by been signe should be d this certificate has been page 2 director.

Vital

Division

or Attending Physician:

Hospital

death

within 24 hours after deatl To the Funeral Director:

funeral

filled in by

completely

Physician/Medical

Be Completed by

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 🗌 Yes

27. Manner of Death Natural 2 Accident

3 ☐ Suicide 4 Homicide 5 Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

CATON AVE, BALTIMORE, MD

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signatu

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		S	State o	f Mai	rylan		artmer <i>rtificat</i>		Health and N	Mental Hy	_	20	10	2226	2.0
		Registrar 1. Decedent's Nam	ne (First, Middi	e. Last)				- 06	Timeat	COIL	Jean	2. Date of De	Reg. I	No.		3. Time of Death	14
Physicia Medic		Robe	ert	Sc	cott		Tı	urking	gton			July 1	.2,	2010	Year	11:35 p.	
Examin		4a. Facility Name (ii	f not institution	n, give stree	at and num	ber)					r Location of Death			4c. County			
<u> </u>		National 5. Social Security N		eran H		7 100/	(ln .m. ln	st birthday)		kVil		8. Date of Bi		ontgo		place (State or Fore	
Funeral Director		514-32-	1785		1 2 □ F		111 yrs. 1a 31	Yrs.	Months	Days	Hours Min.	Jan . 2	ay Year	1929	Cour	Kansas	ign
nd how at	Jr	Usual Residence of 10a. State	f Decedent 10b. County	,		1	10c. City	, Town or L	ocation		<u> </u>				1	10d. Inside City Lim	iits
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th with ms 23 must	ner	3200 N.	Leisu							906	iamania Ovi-in 2 (C-	asif. Van au Na		ted S			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status1 ☐ Never Mari3 ☐ Widowed		rried		Forces? es $2 \square \text{No} 1951-$ Give 1953 If Yes,				cify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity yes or No Rican, etc.)	**	Blac	e - Americ k, White, Whit		
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within 73 giene. er than the Me	Com	Elementary/Sec 12			College (1-	4 or 5+))		DO NOT us				F	edera	ıl Go	vernment	
d be filed value Hygarked other	To Be	17. Father's Name Frank T					-				18. Mother's Nam Mary K.		e, Maide	en Surname)		
should and N is ma		19a. Informant's N	ame/Relations	ship (Type, I	Print)						and Number or Rur						.
and 2 Health em 27 ther to		Edris M 20a. Method of Dis		ingto	n (w	ife)	Y	3200 lace of Disp						Location -		pring, M	
age 1 ent of 1 rt: If it		1 Burial 2 4 Donation	X Cremation	3 Rem	noval from	State	CE	emetery, cre Sapea	matory or o	other place		Date 16,				Maryland	
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Der Im		DK	Holan	9		1	M009	82 9	33 Gi	st A	ve. Silve	er Spri	ng,	Mary	Land	20910	
Physician/		shock, or hea Immediate Cause disease or condition	art failure. List (Final on				he death	n. Do not en	ter the mod	le of dyin	g, such as cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
Medical Examiner		resulting in death)			Due to (or As a c	consequ	ence of):	d	On	en X19				- 1	Websel	2
7 =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):															
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medic	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		1 Live E 4 Pregr 9 Unkn	Birth 2 nant at t	☐ Feta	death 3	☐ Ectopic ☐ Other (s	pregnand pecify) _	су			Mo	te of deliv	Day Year	
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rsiciar s certif	To Be	25. Was case referrexaminer? 1 Yes 2		Hosp	oital:	Innatien	ıt 2 🗆	ER/Outpation	ent 3 🗆 D	Oth	er: 4 Nursing H		idence	6 □ Oth	or (Specif	d	
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Attend death ctor: A y the f	ertificate:	2 Accident 3 Suicide 4 Homicide	Invest 6 Could detern		28e. Place	of Injury	/ - At ho	me, farm, s	M reet, factor		Yes 2 No	28f. Location	(Street	and Numbe	er or Rura	l Route Number,	
ital or / irs after ral Dire	ပ <u> </u>	4 🗆 Homicide	deter	mined	buildir	ng, etc. ((Specify)					City or To					
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check 2 only one)	2 Medical	Examiner:	On the basi	is of exa	mination	and/or inve	stigation, in	my opinie	e, date and place, a on, death occurred a re time, date and pla	at the time, date	and pla	ice, and due	e to the ca	use(s) and manner s	tated.
To the within To the comp	~	29b. Signature and	title of certifie	7	()	1/		1	29	Licens	e number		290. 1	Date signed	(Month,	Day, Year)	
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Stat	te	31. Date filed (Mon	th, Day, Year)	1	32. Re	egistr <i>a</i> r'	s Signat	uye									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Vernon W. Wright, Jr. ቻ/ኘ0/2018 1:15pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 522 Kent Road Glen Burnie Anne Arundel 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 212-44-0200 1 **√2√**M 2 □ F Months Hours 63 777371946 **Yrs Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director MD Anne Arundel Glen Burnie 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code ò 10g, Citizen of What Country? Funeral 522 Kent Road "natural", or items 23a 21060 USA permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked Advisory or Advisory or Advisory. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ρ 1 ☐ Yes 2 No Specify: If Yes, Give white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Auto. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vernon W. Wright, Sr. 2 Kroff Irma 19a. Informant's Name/Relationship (Type, Pript) Mary Louise Wright/ Wife 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Kent Road, Glen Burnie MD 21060 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date Meadowridge Cemetery 7/13/2010 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Doda, Jr Charles I Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service License Victor P. 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory MILLIVE disease or condition Medical resulting in death) Due to (or as a consequence Examiner Cancu 10 tastatio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnam 9 ☐ Unknown Yes _ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 Wo Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Hesidence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: After injury Natural 5 Pendina Accident Investigation within 24 hours after deatl To the Funeral Director: completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

29a, Certifie

3 🗆 29b. Signature and title of certifie

Wheindelwa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khancle (way MD

Registrar DHMH 17 Rev 7/2009 3501,

32. Register's

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0052490

South Hanovust

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G905, 7/20/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year July Physician/ Wolfe 15 4:45 A M Paul M. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>Greater Baltimore Medical</u> Towson Centler 234-56-5735 234-56-5735 . Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Min West Virginia Hours 12/12/1936 73 **Director** Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Numbe ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The man 27 is marked other than "matural", or items 23a or more any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be Funeral 21220 USA 2111 Orems Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes, Give Specify: Completed 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Meat Cutter Eskay Meat Co. 12 Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Goldie Conard Paul Wolfe Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111 Orems Road Middle River Maryland 21220 19a. Informant's Name/Relationship (Type, Print) Kathleen Wolfe (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory Inc. 7/16/2010 □ Donation 5 □ Other (Specify) Baltimore Maryland ture of Fundral Service I censes 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, / complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a Part shock Cause (Final Onset and Death SYSTOU Card Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury 5 for use as the burial-transi physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical tem Tours the Hospital or Attending Physician; The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicit upleted filled in by the funeral director, page 2 should be detached for use as the bur Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month Dav Year 2 🗌 No 1 L Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 2 N Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number (10 Y 2122 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAR 1124 32. Registrar's Signature 31. Date filed (Month, D State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 1 0 22205 State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No. Registrar 2- Detail Reg. No.										
Physicia	an/	Decedent's Name (First, Middle,Last)			2	2. Date of Death Month	Day Year	3. Time of Death				
Medical Exami	ner	Arthur Williams	14	27 -	-tion of Dooth	July 11, 201	10	0357 hrs				
		4a. Facility Name (if not institution, give street and number) 40 East @ St. Paul Road		City, Town, or Loca Hear Spring	ation of Death		4c. County of Washingto					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt			f Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY)	Birthplace (State or				
Director				Months Days	Hours Min.	0/26	/1946	Foreign Country) NY				
		094-36-9474 1 x M 2 F 63 Usual Residence of Decedent				9/20/	1940]	INT				
any		10a. State 10b. County 10c. City, Town	or Location					10d. Inside City Limits				
Maryland 28a-f show	ь	AL Etowah Gadso	den					1 Yes 2 No				
Maryl 28a-1 d at 0	Director	10e. Street and Number	10	of. Zip Code		100	g. Citizen of Wha	t Country?				
ith the Maryland 23a or 28a-f sho notified at once.		914 S. 15th Street		35901			USA					
th wit	Funeral	11. Marital Status 1 Never Married 2		ecedent of Hispani specify Cuban, Me			14. Race - White,	American Indian, Black, etc.				
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 ☐ Ye	s 2 X No sp	pecify:		Specify: B	ol ack				
ırs aft tural'	ğ	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's L	Jsual Occupation	(Give kind of wo		16b. Kind of Busi					
5-0036 led within 72 hours after dygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of	of working life. DO	NOT use retire	d)						
036 vithin ene.	립	- I	nk				unk					
15-0 iiled v Hygi d otho		17. Father's Name (First, Middle, Last)		18.N	,	First, Middle, Ma	•					
2121 Ild be fill Mental F narked event, 1	Be	Henry Williams 19a Informant's Name/Relationship (Type, Print) 19i	h Mailing Ad	dress (Street and	LUC111	e Wiggil	OS er. City or Town.	State, Zip Code)				
MD 21215-0036 1 2 should be filed within 7 th and Mental Hygiene. 1 27 is marked other than umatic event, the Medisa	٩	Bettie M. Williams		outh 15t								
		20a. Method of Disposition 20b. Place of		(Name of cemete		Date	20c. Location - C	ity or Town, State				
Baltimore, bernit. Pages I ar Department of Hee important: If ite		Burial 2 Cremation 3 Removal non state			7/14	/2010	Glen Bu	rnie. MD				
Baltimo permit. Page Department of Important: injury or otd	ı	21. Signature of Funeral Service Licensee	rnie, MD al Home									
E P P W		T. Harman										
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):						Death				
		b										
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause										
	Examiner	colleges or injury that initiated events resulting in death) Last events resulting in death) Last										
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ords, F w requires as been sign	Completed					24a. Was ar autopsy	y pri	ere autopsy findings available or to completion of cause of ath?				
Rec The la	mo					perform 1 Yes 2	No 1	Yes 2 No				
tal Restant: The certificate ector, page	Bec	25. Was case referred to medical examiner?		IOth.	Death (Check or							
Physic r this	2	1 Yes 2 No No Inpatient 2 ER/O	Outpatient 3 Time of Injur		· L Ivaroning		esidence 6					
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ra after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ë E	(Month Day Year)	7 hrs		a la la	jected drive	r of motor ve	hicle who collided with				
Sior	cati	2 Accident Investigation 28e. Place of Injury - At home, fix	arm, street, fr		TI.		when fleeing reet and Number	or Rural Route Number, City				
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / H		•		or Town, Sta 0 East @ St. F	ate) Paul Road, Cle	ar Spring, Md.				
Hospi 24 hou Funer tely fil	<u>8</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de										
To the Hos within 24 h To the Fur	edical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	investigation,	, in my opinion, de	ath occurred at							
H % H 3	Me	29b. Signature and title of certifier		29c. License nu				(Month, Day, Year)				
		Carol Hallan		O.C.M.E	I.		July 11, 201	U 				
5		30. Name and address of person who completed cause of death (Item 23a)	Donn Ct-	not Paltima-a	MD 21201							
	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
S ⁱ Regis	tate trar	31. hate filed (Month) per (lear) Server 32. Registrar's Signature	عمسا									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Barbara Jean Walsh 2010 10:54 A.M July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1836 Fairmount Road Hampstead Carroll 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XXF Months Hours Min. (Month, Day, Year ar. 16, Director 70 360-32-9875 1940 Mar. Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Carroll Hampstead 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? United States Funeral 1836 Fairmount Road 21074 America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 242No Black, White, etc. 1 Never Married 2XX Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates and Mental Hygiene. s marked other than "natura umatic event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) 12th Disability Claims Clerk Administration Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Kempf Mildred Tipton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Walsh (Husband) 1836 Fairmount Road, Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ali Faiths Crematory & Chapel July 15 1 ☐ Burial 2XXXCremation 3 ☐ Removal from State 4 Donation 5 Othe (Specify) 2010 Manchester, Maryland 21. Signature of Fune 1 Series Lice 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between stock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death erebrovasculax Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reauring to immediate cause. Enter Underlying Examine Due to (or as a consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year ed by the a detached f 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? Yes 2 No 2 X No 1 Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1: Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rumwiya, m 51705 07-14-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hampstead, MD 21074 ANSURIVA Hanores 2111 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 16201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan	d / Depa	rtment of	Health	and N	/lental Hy	giene, Reg. No.	2010	22207
			Registrar 1. Decedent's Name (First, Middle	, Last)			imouto o	- Doutin		2. Date of De			3. Time of Death
	Physicia Medic		MARTHA MAE WY	CHE						July	14^{Day}	201	0 0443 A M
'n	Examin		4a. Facility Name (if not institution,	, give street and nui	mber)		4b. City, Town	, or Location	of Death		4c. 0	County of Dea	ith
~ ^			Holy Cross Ho					Sprin		I a a		ntgome	
	Funeral Director		5. Social Security Number 228–30–2086	6. Sex 1 M 2 X F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Bir (Month, Da June 22		Cr	rthplace (State or Foreign ountry) Oria, VA
-			Usual Residence of Decedent								-, -,-		
	yland f sho ed at	tor	10a. State 10b. County			y, Town or Loc	ation						10d. Inside City Limits 1 5d Yes 2 □ No
	e Mar r 28a notifi	Director	MD Mont §	gomery	Whe	eaton	10f. Zip Cod	9			10a Citiz	en of What C	
	/ith th	ra	4011 Randolph F	Pond			2090				rog. Oniz	USA	ourity.
	ems r mu	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	3. 13. V	Vas Decedent d	f Hispanic Or	igin? (Spe	ecify Yes or No-	1	4. Race - Am	
õ	fter de , or it amine	þ	1 Never Married 2 Married	ried Armed Fr 1 Yes If Yes, Gi	2 X No		Yes, specify C			rican, etc.)		Black, Whi	•
3	ours a rtural'	sted	3 ☑ Widowed 4 ☐ Divorced	Year or E	ates.							pecify: B1	
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7	within giene. er tha , the I		Elementary/Seconday (0-12) 12th	College (1-4 or 5+)	Cust	odian				Fed	eral G	overnment
yland	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, L	•				1		e (First, Middle, Butts	, Maiden Si	urname)	
2	d Men d Men marke natic	-	Silas L. Jones 19a. Informant's Name/Relationsl			401 44 35	A 1.1 (O4				or City or T	Town State 7	Vin Codel
o N	2 sho Ith an 27 is r traui		Mary P. Wainwr		ughter					al Route Numbe (issimm			
ē,	1 and of Hea item othel		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name of natory or other)			Date			r Town, State
	Page nent c ant: If ary or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			vland Na	tional			21, 2010			
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fire 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee	H	71	Name and Ad	dress of Facili	ity Joh reet :	nnson & , NW, W	Jenk ashin	ins Fu gton,	neral Home DC 20011
			23a. Part 1. Enter the disease, or shock, or heart failure. List d	complications that	caused the deat	h. Do not ente	r the mode of c	lying, such as	cardiac (or respiratory a	rrest,		Approximate Interval Between
P	กรูร่เวลาเ	7 S	Immediate Cause (Final disease or condition		IRATORY								Onset and Death
	Medical Examiner		resulting in death)		(or as a conseq		T A						
		Jer	Sequentially list conditions, if any, leading to immediate	b. —	RATION 1		IIA						
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	ate be executed ohysician and the burial-transit	dical Examiner	resulting in death) Last	Due to	(or as a conseq	uence of):							
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Š i	e atter d for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☒ No		Birth 2 Teti gnant at time of		Ectopic pregr Other (specify					Month	Day Year
	t the company the stache	Phy	9 Unknown Part II. Other significant condition			sulting in the u	ndarlying cause	niven in Parl	+1	220 Did	tobaga us	o contributo t	to the cause of death?
	res tha signec I be d	Completed by Physician/Me	Part II. Other significant condition	Jiia contributing to	death but not let	Jaking III III a	naonying oddoc	givoiriirraii					Probably 4x Unknown
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necords,	e has age 2 s	omp								auto perf		death?	es 2 🖾 No
<u> </u>	an: Ir tificat tor, pă	Be C	25. Was case referred to medical				26	. Place of Dea	ath <i>(Chec</i>		2 XX INO	121	2 22 110
	ysici lis cer direc	TO E	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2	ER/Outpatier	t 3□DOA	Other:	lursing H	ome 5 Res	idence 6	Other (Spe	ecify)
5	ing Pl		27. Manner of Death 1 Ⅺ Natural 5 ☐ Pendir	/8.4-	e of injury nth, Day, Year)	28b. Time of injury	l v	njury at /ork?	٦.,	28d. Describe	how injury	occurred	
2101	death death ctor: / y the f	Certificate:	2 Accident Investi	not be 280 Plac	e of Injury - At h	ome, farm, stre		Yes 2	l No	28f. Location	Street and	Number or R	ural Route Number,
Division of Vital	al or A s after I Direct		4 ☐ Homicide determ		ding, etc. (Specif				_		wn, State)		
-	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	(Check 2 Medical I	Physician: To the Examiner: On the ba	asis of examination	n and/or invest	igation, in my o	oinion, death o	occurred a	t the time, date	and place,	and due to the	e cause(s) and manner stated.
	vithir To th comp	Σ	29b. Signature and title of certain	120	US.	57P	29c. Lice	ense number 5471			29d. Date	15, 20	oth, Day, Year)
	1		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type, F	rint)						
	5V		Yeheyis T. Neg	ussie, MI	, 1500	Forest	Glen R	oad, S	ilve	r Sprin	g, Ma	ary1and	1 20910
	Stat Registra		31. Date fill of 1, 62010	Deneura 32.	Registrar' Signa	park	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 22208 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2010 **Physician** July 2, 11:50 AM Calvin Ziegler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 827 N. Arlington Street #901 Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Numbernk 8. Date of Birth (Month, Day, Year) Jan 2, 1932 Birthplace (State or Foreign Country) Ink 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ₩ M 2 🗆 F 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, the Maddeal Examinar must be notified at MD Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 230 any injury or other traumatic event. 21217 USA Completed by Funeral 827 Arlington Street #901 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unk Black, White, etc. 1 Never Married 2 Married black 1 □Yes 2 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry un 16a. Decedent's Usual Occupation un 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1520 W. North Avenue; Baltimore, Maryland 21217 George Zieglar - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5 Dotner (Specify) in state 21. Sign ture of a more! Service Lieu 22. State Anatomy Board; 655 W. Baltimore Street Warde Director Baltimore, Maryland 21201 23a. Part 1 Enter the disease or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, reaching to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events This to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ANo After this certificate 1 ☐ Yes 2 🗷 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifler Medical (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 57543 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 W. BALTIMURE ST. BALTIMURE, MD 21823 PREETINOGR SANDHU MD 31. Date filed (Month, Day, Year) 32. Resident's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Zimecki Albert 33 P M Physician/ Medical 4b. City, Iown, or Location of Death Lanham 4a. Facility Name (If not institution, give street and number)
Doctor's Community Hospital ⁴C County of Death George's Examiner 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 95 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** (Month, Day, Year) 09/18/1914 Days Hours Min. 1 🕱M 2 🗆 F 102-07-8129 NJ Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Prince George' MD Lanham 1 Yes 2X No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò event, the Medical Examiner must be 20706 Funeral 9885 Greenbelt Road, 23a with items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. and Mental Hygiene. is marked other than "natural", or þ 1 Never Married 2 Married Specify: White 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Textiles Textile Printer Be permit. Page 1 and 2 should be filed or Department of Health and Mental Hyy Important; If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname, Baltimore, Maryland 17. Father's Name (First, Middle, Last) Mary Washeleski Vincent Zimecki 2 any injury or other traumatic ^{19a.} Informant's Name/Relationship (Type Print) Gloria Friar / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Cheverly Circle, Cheverly, MD 20785 20c. Location - City or Town, State 20h Place of Disposition (Name of 20a. Method of Disposition remeter, crematory or other place)
Final Journey Crem. 7/15/2010 1 Burial 2X Cremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD of Funeral Service Licensee Dorota Marshall 21. Signature 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ton outin Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlyin Cause (Disease or linjury Due to (or as a consequence of) requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialending physician ar use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav ģ Pregnant at time of death Yes 2 ☐ No the 9 Unknown g | Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 20 M 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has b. autopsy performe 1 Yes 2 No 1 🗆 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA မ 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury Certificate: (Month, Day, Year) injury Natural 5 Pending 1 ☐ Yes 2 ☐ No M Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death ¥300 usul Lee 10 0 2 31. Date filed (Month, Day, Year) 32. Re State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 795 Medical Facility Name (if pot institution, give street and number) Examiner 4b. Çity, Town, or Location of Death County of Dea enter 5. Social Securify Numbe 7. Age (In yrs. last birthday) If Under 1 Year | I Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Min. Days Yountry) are **Director** Yrs. N/AUsual Residence of Decedent or 28a-f show J. Hygiene. I other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Xyes 2 No wood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

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☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown pinous peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law To the Funeral Director: After this certificate has filled in by the funeral director, page 2: autopsy performed? death? 1 ☐ Yes 2 🛣 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 1 Tes ျှ Other: MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledg te and place, and due to the caucale) and manner as stated 29b, Signature and title of certifier 2 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 State Registrar

2001 Medical Parkway 31. Date filed (Month, JUN 3 0 2010

James Haddock

32. Registrar's Signature

Annapolis, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28, 2010 Physician/ June 0333 AM Juanita Joson Arenas Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours 04777271923 Philippines 86 Director 555–63–6966 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d, Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notified at 10a, State 10b. County the Maryland Director 1 Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20879 United States 8204 Everbloom Court permit. Page 1 and 2 should be filed within 72 hours after death be obsartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify Specify: Filipino 3 X Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 16a Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 3 Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Reduarda Realin Dominador Joson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 255 Augustine Court Kearneysville, WV. 25430 Thelma A. Ocampo (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July Date 02 1 XBurial 2 Cremation 3 Removal from State All Souls Cemetery Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specity) 2010 21. Sign tur of Funeral Servi Licens e 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be reconstructed by the contract of the contr Approximate Interval Between Onset and Death Immediate Cause (Final Physician mins. disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 pronths?

1 Yes 2 No
9 Unknown Year Month Dav Pregnant at time of death Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by t completed filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ ER/Outpatient 3 DOA 1 Inpatient 2 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and some investigation, or many operations of the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 June 29, 2010 3

Registrar
DHMH 17 Rev 7/2009

State

Suanita

23A-0K

Medica

82. Registrar's Signature

Center Drive, Rockville, Md. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- 9901

Klein

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	f Marylan	-	artment of		and N	lental Hyg		110	22212	
_			Registrar	Tack		Cer	tificate of	Death			10 31 110	110	22212	,
	Physicia		Decedent's Name (First, Middle, Mary	Last)		Be	ach			2. Date of Dea June 2.		Year	3. Time of Death 7:24 P M	
->	Medic Examin		4a. Facility Name (if not institution,	give street and numi	ber)		4b. City, Town, o	or Location	of Death	0 0110 0.		y of Death	7 - 2 - 1	-
	<i>ś</i>		Heart Homes at				Annapo					Arun	ıde1	_
	Funeral Director		5. Social Security Number 228-32-0531	6. Sex 1 □ M 2 및 F	7. Age (In yrs. la 81		If Under 1 Year Months Days		Min.	8. Date of Birth 06/30/	1928	9. Birthr Coun	olace (State or Foreign try) VA	
	d tow	_	Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ation							_
	larylan ka-f sh ified a	Director	MD Anne A	runde1		napoli							0d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	the N a or 28	Ξ	10e. Street and Number				10f. Zip Code			- T	10g, Citizen of	What Cour	ntry?	-
	th with ms 23; must	Funeral	3023 Arundel on				21403					USA		_
(0	or iter	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Ford 1 Yes	ces?	5. 13. V	Vas Decedent of F Yes, specify Cub	Hispanic Ori an, Mexicar	gin? (Spe 1, Puerto	cify Yes or No- Rican, etc.)		ce - Americ ck, White,		
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ted b	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dat		1	☐ Yes XX No	Specify:			Specify	Whi	te	
15-(72 hou n "nat fedica	Completed	15. Decedent (Specify only highes			(Give I	ent's Usual Occup and of work done	during mos	t of worki	ng	16b. Kind of E	Business Inc	dustry	
212	within giene. er thai		Elementary/Seconday (0-12)	College (1-4	4 or 5+)		NOT use retired,		st		US 1	Navy		
pu	filed tal Hyged of other event.	To Be	17. Father's Name (First, Middle, La	,				1		e (First, Middle, I		ne)		
Maryland	should be and Menta is marked raumatic e	-	Charles Babbitt 19a. Informant's Name/Relationshi			T				Blanch P				_
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demoval from 6	20b. P	lace of Dispo	sition (Name of natory or other pla	- :		Date	20c. Location			-
Ĭ	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Sp			Laware	Veterans	Cen		/2010	Millsbo	oro, I)E	
Ba	permi Depar Impo any ir once,		21. Signature of Funeral Service Lic	censee		22 H	Name and Addressive Ardesty	ess of Facilit Funer	y al H	ome P.A.	12 Rid Annapo	gely	Aye MD 21401	
			23a. Part 1. Enter the disease, or o shock, or heart failure. List or	complications that cally one cause on eac	aused the death	n. Do not ente	r the mode of dyir	ng, such as	cardiac o	r respiratory arre	est,	i i	Approximate Interval Between	
7	Physician/ Medical)h	Immediate Cause (Final disease or condition resulting in death)		ONAR	Y AR	TERY D	ISCA	SE				Onset and Death	
	Examiner		resulting in death)	Due to (o	r as a consequ	ience of):								
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (o	r as a conse _u u	ence of								-
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3/60	certificate nding physuse as the		IS SERVALE.	d										-
Box 68	th cert ttendir or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		irth 2 🗌 Feta	I death 3	Ectopic pregnan	су				ate of delive	*	
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л. О	that the	by PI	Part II. Other significant condition	_		_	, - 0			23e. Did tol	oacco use conf	tribute to th	e cause of death?	
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ř	in: The ificate or, pag		25. Was case referred to medical	1			26 P	lace of Deat	th (Chook	1 🗆 Yes		1 Yes	2 🗌 No	_
VITS	nysicia nis cert direct	To Be	examiner? 1 Pes 2	Hospital:	npatient 2	ER/Outpatien	Oth	0.81		me 5 🗆 Reside	ence 6 Oth	er (Specify)	ASSISTED LIVING	-
Division of Vital Records,	ling Pt		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date o (Month	f injury , <i>Day, Year)</i>	28b. Time of injury	28c. Injur work	y at </td <td>2</td> <td>28d. Describe ho</td> <td></td> <td></td> <td></td> <td></td>	2	28d. Describe ho				
SIO	Attend death ctor: / y the f	Certificate:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be	of Injury - At ho	me. farm. stre	M 1 L et, factory, office	Yes 2		28f, Location (St.	reet and Numb	er or Rural	Route Number	_
2	tal or / s after al Dire ed in b		4 ∐ Homicide determin	building	g, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	,,,			City or Town		er or riurar	rioute ivanibei,	
-	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	edical	(Check 2 Medical Ex	Physician: To the be- aminer: On the basis	of examination	and/or investi	gation, in my opini	on, death oc	curred at	the time, date an	d place, and du	e to the cau	ise(s) and manner stated.	
	fo the vithin 2 o the comple	Σ	only one) 3 Certifying N 29b. Signature and title of certifier	lurse Practioner: To	the best of my	knowledge, d	eath occurred at the 29c. Licens	e time, date	and place	e, and due to the	cause(s) and m 9d. Date signe	anner as sta	ated.	-
	->F0		> Illypus C	UM	eces			023	33		6/2		*	
	5 _w		30. Name and address of person w		eath (Item	23a) (Type, Pr								_
	W Stat	2	31. Date filed (Month, Day, Year)	32. Rec	110 h	VOSF 15.	ME DR, 7	310	PI	LINCE	FREDE	ZICKA	10 20678	_
	Registra		JUN 3 0 2010	anun	gistrar's Signati	back	1				_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:42pm ^M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel 322 Riding Ridge Rd. . Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2XXF Months Days Hours 220-62-5101 167297 1953 **Director** 56 Usual Residence of Decedent show 10a. State 10d. Inside City Limits at 10c. City. Town or Location filed within 72 hours after death with the Maryland Director r 28a-f s notified Annapolis 1 Yes XX No MD Anne Arundel 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 21403 USA 322 Riding Ridge Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Transportation Administrative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic ones. Harlan Carlson Beverly Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21403 Riding Ridge Rd. Dennis Boykin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 7/2/2010 Silver Spring, MD Gate of Heaven Cem 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Ridgely Ave. Annapolis, MD 21401 Part Y. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nse and Death Immediate Cause (Final Physician Vanan Canal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Due to (or as a consequence or). Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown signed by the a d be detached f 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 2- No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be Other: 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tyes 2 🗌 No Investigation Could not be 2 Accident Suicide within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier MI 6/29/2010

State Registrar 31. Date filed (Month

FW Restzete Rd Sute 300 Angels

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

JUN 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Marylai		artmen					Reg. No.	010	22211	+
	Physici		1. Decedent's Name (,							2. Date of D Month	Day	Year	3. Time of Death	
7%	/Medic	al	CAROL AND					41.00			(5	JUNE	28	2010	4:21 P	Α
ر را	Examin	er	4a. Facility Name (If no							Location	of Death			ounty of Death		
		86	ANNE ARUNI 5. Social Security Num		Sex	7. Age (In yrs	. last birthday	ANNA If Under			24 Hrs.	8. Date of Bi		E ARUNI 9. Birth	DEL place (State or Foreig	<u></u>
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215-0036 ithin 72 hours af	astu.	Completed		Decedent's	Education grade completed	d)	16a. Dece	dent's Usua kind of woi	l Occupa	ation	st of work	kina	16b. Kind	of Business/Ir	ndustry	
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N g	Hygie ther t		17. Father's Name (Fil	et Middle La	2		TEACI	IER'S	ALD	19 Moth	or's Nam	e (First, Middle	1	ATION		
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Maryland nd 2 should be file	and Mental Hygie Is marked other t sumatic avent, In	ဥ	19a. Informant's Name		(Type, Print)		19h Maili	na Address	(Street a			ral Route Numi	per City or T	own State Zi	D Code)	-
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Baltimore,	Department of I	Ī	21. Signature of Fune			7.	2	2 Name an	d Addres	ss of Facili	ity				IOME P.A. 21619	
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Ing F	h. After thi funeral c	<u>o</u>		5 Pending	(Mo	e of Injury onth, Day Year)	28b. Time o Injury		8c. Injun Worl			28d. Describe	how injury o	occurred		
Vision of Vita	death ctor; / the fi	Icat	2 ☐ Accident 3 ☐ Suicide	investigat 6 ☐ Could no	t be	ce of Injury - At h	30ma farm et	M factoria		Yes 2	JNO	29f Leastion	(Ctrant and I	Number of Pu	al Route Number,	
Division of	after Direction by	erti	4 Homicide	determin	ed 200. Flat buil	ding, etc. (Spec	ify)	гөөт, тастогу	, onice			City or To	own, State)	varioer or hai	ai noute ivamber,	
Hospita	within 24 hours after death To the Funeral Director; completely filled in by the	edical Certification:	29a. Certifier 1 (Check only 2) one)	Certifying Medical Ex	Physician: To the	ne best of my kn basis of examin inner stated.	owledge, deal ation and/or in	h occurred avestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the	cause(s) ar , date and pl	nd manner as lace, and due	stated. to the cause(s)	
To tha	o the		29b. Signature and tit	of certifier	0/.	A		290	License	e number			29d. Date :	signed (Month	Day, Year)	
	> - 0			h 91	11/011	moth	nn	4	10	C34	144)	(16	127/	2010	
Ľ	76	- i	30. Name and address	of persen wt	o completed car	use of death (Ite	m 23a) (Tvpe.	Print)	,)		^	10	1		
T.	de		1/6	V	VEIN.	1/-10	60	0/1	10%	1-1	1 1	1/6	. Ho	nopul	1 m	
	Sta		31. Date filed (Month,	Day, Year)	32.	Registrar's Sign	ature	60. N.	1	1		· · /		1	/	
	Registr	ar		JUL - 1	L 2010 🗡	Moure	19.19	Tarre								

DHMH 17 Rev 1/2001

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AMEND ITEM#25,28a,b,e,f,perME,G906,8/27/2010,WS20 1 0 222 1 5

State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 222 1 5 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Tse-lin Carlene 13:47 pm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Clinton Maryland Southern Prince George 100 1 pol 9. Birthplace State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Month Day 1 M 2 X F Months Hours 7304 Director <u> 577 - 50 -</u> Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits notified 28a-f 1 Yes 2 No Prince Brandywine Maryland 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Lot 10505 Cedarville 20613 10-1 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: If Yes, Give Year or Dates 3 Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Domeste tomenske Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname and Mental F မ Cutherbertson traumatic Unlinuwn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health au Important: If item 27 is any injury or other trauonce. Mechani GATES Ronald 29946 20659 Edina Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Metropolitan 4 ☐ Donation 5 ☐ Other (Specify) lexandria permit. 21. Signature of Funeral Sen ce Licensee 22. Name and Address of Facility M(1) 1589 20648 23a. Part 1. Enter the dist ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail i.e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYDERTHERMIA ACUTE disease or condition resulting in death) COMPLICATING Medical Due to (or as a consequence of): Examiner ATHERUSCLE RUTTE CARBIOVASCUL Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Pregnant at time of death Month Day 1 Yes 2 5 the detached 9 Unknown P.O. this certificate has been signed by ral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, IT YPERTENGION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown MORBID OBESITY. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 N death? Hospital or Attending Physician: The 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 DER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury Fnd (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Lol, After Findiniural:00mm Natural Coldent 5 Pending 1 ☐ Yes 2 ☐ No Juse 28, 2010 4 0,000 within 24 hours after death

To the Funeral Director; of completed filled in by the Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 4 Homicide Ocation (Street and Number or Rural Route Number, City or Town, State) 105 05 Ceclariale Rd Aut 10 Brand, when his 20613 determined Mobile Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m. mo 1c mal D50689 0612812010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILK NOAM AT ANOM DO SUNTHERN MARY HU (D) TAL CENTER 750 SURRATTES 12 GAD 31. Date filed (Month, Day, Year) 3 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 22216 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 27 Physician/ 2010 9:15 A June Shirley W. Berger Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles Indian Head 3800 Marvin Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign Country)
Connecticut **Funeral** Hours 1 □ M 2 XXF Director 927 82 577-38-2525 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 □ No Maryland Charles <u>Indian Head</u> 10g. Citizen of What Country? Funeral USA 20640 <u>3800 Marvin Drive</u> . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White If Yes. Give 3 XXWidowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing 12th. Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Bessie Josephine Apley Lloyd Ward Whitney and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B780 Marvin Drive, Indian Head, MD. 20640 Pam Dottellis/ Daughter injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State June 30, 2010 Glen Bernie, MD. 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Lie 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD 20601 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of) resulting in death) Last bunatattending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month 1 Yes 2 Who 9 Unknown Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been so tuneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Yes 2 No the Hospital or Attending Physician: ' thin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 27 ပ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide work? 5 Pending 2 🗌 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Day, Year

State

Box 68760

P.O.

Records,

Division of Vital

31. Date filed (Month, Day, Year) JUL 0 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Begistrar's Signature

Registrar

				partment of Health and Nertificate of Death	ental Hygien Reg. r	
	Physicia		1. Decedent's Name (First, Middle, Last) Tony Bras	sh	2. Date of Death June 27,	3 Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number) Kline Hospice House	4b. City, Town, or Location of Death Mt. Airy		4c. County of Death Frederick
	Funeral Director		5. Social Security Number 233-56-8271 6. Sex 1 № 1 7. Age (In yrs. last birthda, 1 № 1 72 Yrs	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign West ^{int} Virginia
	yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Frederick Mt. Ai:			10d. Inside City Limits
	h the Mar la or 28a- be notifie	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	1 ☐ Yes 2 🕅 No Citizen of What Country? USA
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		12513 Bills Court	21771 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Baltimore, Maryland 21215-0036	hours afte natural", c lical Exam	leted by	3 Wildowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a. De	1 ☐ Yes 2 🏝 No Specify: cedent's Usual Occupation	. 16b.	Specify: White . Kind of Business Industry
21215	within 72 giene. ier than "i t, the Mec	Completed	Flementary/Seconday (0-12) College (1-4 or 5+)	ve kind of work done during most of work DO NOT use retired) elephone Repairman	ing	Utilities
yland	ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Ralph Brash	18. Mother's Nam Susi	e (First, Middle, Maide 2	en Surname) Shook
, Mar	nd 2 shou ealth and m 27 is m		Rita Brash/Wife 125	ailing Address (Street and Number or Rur 13 Bills Court Mt	. Airy, MD	21771
imore	Page 1 ament of Hament of Hament of Hament of Hament If itel		1V Review 2 Commention 2 Removed from State Cemetery, C			Location - City or Town, State uitland, MD
Balt	permit. Depart Import any inj			22. Name and Address of Facility St. 1621 Opossumtown P	ike, Frede	
7	Physician/	a .	23a. Park: Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	neter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
	Medical Examiner	Į.	GT blend			Smonths,
	routed and transit a	Examiner	Sequentially list conditions, if any, leading to immediate educe. E for U Jarlyn g Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
09	ate be exe ohysician a the burial-	Jical	resulting in death) Last Due to (or as a consequence of): d.			
Division of Vital Records, P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Meo	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	B		23d. Date of delivery Month Day Year
s, P.O.	ires that th signed by Id be detac	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		to use contribute to the cause of death?
Record	The law ate has page 2	Completed by			24a. Was an autopsy performed 1 Yes 2 🗹	24b. Were autopsy findings available prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{No} \) No
a	ician: Sertific ector,	Be	25. Was case referred to medical examiner? 1 Yes 2 15 No Hospital: Input last 2 TENOvites	26. Place of Death (Chec		
<u>></u>	Phys r this eral dir	∋: To	1 Inpatient 2 ER/Outpated 27. Manner of Death 28a. Date of injury 28b. Time	tient 3 🗆 DOA 4 🗀 Nursing H	ome 5 Residence 28d. Describe how in	6X Other (Specify) Hospice
onc	ath. r: Afte	icat	1 Matural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No		
Divisi	tal or Atter rs after de al Directo	al Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, deal check only one) 1 ★ Certifying Physician: To the basis of examination and/or in the basis of examination and or in the basis of exa	restigation, in my opinion, death occurred a e, death occurred at the time, date and pla	t the time, date and pla ce, and due to the caus	ace, and due to the cause(s) and manner stated. se(s) and manner as stated.
	To vith		29b. Signature and title of certifier	29c, License number D0067671		Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Typ			
/	5714		Mark Goldstein 501 W. Seventh		21701	
	Stat Registra		31. Date filed (Month, Day, Year) JUN 3 0 20 32. Registrar's Signature	Sparked		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. NoZ U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Ам 2010 Marie Elizabeth Brancati May :58 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E1kton Cecil 115 Dennis Drive 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Month, Day, Year 10/6/1946 1 ☐ M 2 🛣 F Director 222-28-3612 63 DE Usual Residence of Decedent ı "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic. 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Elkton MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21921 United States <u>115 Dennis Drive</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Specify: White 1 ☐ Yes 2 X No Specify. 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salon 12 Hairdressing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Velma Elizabeth Gano Maurice Whitmer Eachus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Dennis Drive Elkton, MD 21921 George A. Brancati/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 🙀 Removal from State 6/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory Newark, DE 21 Signature of Peral Ice Lice See 22. Name and Address of Facility Spicer-Mullikin FH Examine

Ph_sician/ Medical **Examiner**

Baltimore, Maryland 21215-0036

by Physician/Medical

Completed

Medical Certificate: To Be

H3411/L

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate has

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

1 John &	Why 1000 N. DuPont Pky New Castl	e, DE 19720
23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
resulting in death)	Due to (or as a consequence of):	54EAR)
Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence of):	
that initiated events resulting in death) Last	C. Due to (or as a consequence of):	
IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
Part II. Other significant conditions of		use contribute to the cause of death?
	24a. Was an autopsy performed? 1 ☐ Yes 2 1	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner? 1 X Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 \sqrt{Yes} 2 \sqrt{No}	
3 ☐ Suicide 6 ☐ Could not i 4 ☐ Homicide determined		nd Number or Rural Route Number, e)
(Check 2 Medical Exam	visician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) a niner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place rese Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause	e, and due to the cause(s) and manner stated.
29b. Signature and title of cartifier	29c. License number 29d. D	ate signed (Month, Day, Year)
	Impleted cause of death (Item 23a) (Type, Print)	cheru, M)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARIE 1:10 AM Line G. BOOTH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Keed Boonsboro, washinaton tahrney If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Hours June 4 Months 215-64-5542 Min. 98 1912 Washington. DC Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Washington Boonsboro 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be Funeral 8507 Mapleville Road 21713 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. ? is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Martin Schilling Fischer Margrate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath an Important: If item 27 is any injury or other trau Booth. Jr. 18334 Possum Point Road Raymond L / Son Dumfries. Virginia 22026 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) ctauffer Crematory 06/29/2010 Frederick, Maryland Signature of Europal Service Lice 22. Name and Address of Facility Bast-Stauffer Funeral Home. PA 7606 ∩ld National Pike Boonsboro, MD 21713 23a. Pay 1. Enter the disease, or complication shock, or heart failure. List only one call to that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ ibertension disease or condition resulting in death) Medical Due (or as a consequence of): Examiner Renal insufficien Sequentially list conditions, Examine If any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Dementia attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Month -Day Year Pregnant at time of death 5 Other (specify) ed by the 9 Unknown g Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Hospital or Attending Physician: The law has page 2 s autopsy within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 X No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kate in Smith CRNP R128088 6/28/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-3

DHMH 17 Rev 7/2009

State

Registrar

Kate M. Smith CRNP

JUN 29 2010

31. Date filed (Month, Day, Year)

Hagerstown, MD

1126 opal Ct.

State of Maryland / Department of Health and Mental Hygiens, 22220 for State Registrar Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 900 M 27 2010 Vassie Orville BARNHART June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 20432 Millers Church Road Hagerstown Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M M 2 □ F Funeral Days Voar Hours Months 94 3 1915 Pennsylvania Dec. Director 172-14-5764 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Experience must be notified at 10a State 10b. County 1 ☐ Yes 2X No Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 21742 20432 Millers Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 X Yes 2 ☐ I If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. à White 3 Widowed 4 Divorced WW II Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Truck Manufacturing Machinist 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie May (unknown) Richard Barnhart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If item 27 is any injury or other trau 20432 Millers Church Road, Hagerstown, MD. 21742 <u>Joan</u> L. Barnhart - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Mem. Park 7/1/2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 🛂 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Day Ye ar Month in the past 12 months? 5 Other (specify) signed by the a d be detached fo P.0. Tyes 2 TNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown been si should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has al director, page 2 1 ☐Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27 Manner of Death 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mesoner stated. 29d. Date signed (Month, Day, Year) icense number 29b. Signature and title of certifie (Item 23a) (Type 31. Date filed (Month State JUN 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Vear 7:00 PM James Barnett 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In vrs. last birthday) 8. Date of Birth
(Month, Day, Year)
Sep. 4,1948 **Funeral** 1 X M 2 □ 144-40-1811 Director 61 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County 1 X Yes 2 □ No Hagerstown 10f. Zip Code 10g Citizen of What Country? Funeral 1500 Pennsylvania Ave. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 965If Yes, Give 1965Year or Dates. 1971 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Completed 1971 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Unknown Unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19727 Meadowbrook Rd. Hagerstown, MD 21742 Marion Hardin-friend 20a. Method of Disposition
1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory 6-29-2010 4 Donation 5 Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ouglas A. Flery Funeral Home Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Respiratory Immediate Cause (Final Physician SECONDERY disease or condition resulting in death) Medical Due to (r as a consequence) f): Examiner In Puller Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ō Month Dav Yea Pregnant at time of death signed by the a d be detached for 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 Unknown Completed ebrovescular accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe Hypertensi certificate 1 Yes 2 No 25. Was ca referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 - No မ 1 Impatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completed filled in by the fur Investigation 6 Could not be 1 ☐ Yes 2 ☐ No ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0061

State

Wancisco

31. Date filed (Month,

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ANTIETUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Physicia Medical Exami		1. Decedent's Nam		e,Last) s Bertrand,	Jr.						2. Date of Month July 8,	Death Da			Time of Death 2030 hrs
*		4a. Facility Name (i		n, give street and nu	ımber)			_		Location of D			4c. County of I	Death	
Funeral		5. Social Security N		6. Sex	7. Age (In yrs. last bi	rthday)	Bowi If Und	der 1 Yea	ar If Under 2	4Hrs. 8. Date of	of Birth(M	Prince Ge		ace (State or
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/ any		Usual Residence of 10a. State	Decedent 10b. County		10	Dc. City, Town	n or Loca	tion					<u> </u>	100	d. Inside City Limits
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the Mar	Director	15620 Tw		ey Court				10f. Zip	209	906		10g. C	itizen of What USA	Country?	
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after dez al", or i	by Fu	3 Widowed		1 Yes orced If Yes, Give Yea or Dates:	2 _	No No	1	Yes 2	x No	specify:			Specify:	Black	
hours a "natura"	ted b	15. Decedent's Ed		cify only highest grad						tion (Give kind . DO NOT use	of work done retired)	16b	. Kind of Busin	ess/Indus	stry
036 vithin 7; ene. er than	Completed			3	1010.		St	udent	:				Educati	ian	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be Co	17. Father's Name (Tereston		Last) Bertrand, S	ēr.						ame (First, Midd Bertrand		en Surname)		
imore, MD 21215-0036 men et and 2 should be filed within 72 hours after death with the Maryland men of Heath and Mental Hygiene. iant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Na Joan Betra				19					or Rural Route				
e, MD I and 2 sho Health and item 27 is	1	20a. Method of Disp	position			20b. Place	of Dispos	sition (Nar	me of ce	metery,	Date		Location - Ci		
Baltimore, permit. Pages I ar Department of Hes important: If ite		1 Burial 2 1 Donation 5		3 Removal fro	om State	Me trop					July 15 2010		ilver Spr	_	- ,
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati.		21. Signature of Fur	neral Service	Licensee 4	0	Der C	22.1 50	lame and ancis O Uni	Address	of Facility OIT ins I ty Blvd.	Tuneral H	ome Ir ver Si	nc. oring, MI	2090	01
Physician /Medi		23a. Part I. Enter the failure. List onl	e disease, or o	complications that ca	aused the	e death. Do n								Ap	proximate Interval etween Onset and
Examiner	Ì	Immediate Cause (For condition resulting		a. Cardia Due to (or as a			mia							+	Death
	<u>-</u>	Sequentially list cor if any, leading to im		b. Corona Due to (or as a			anor	naly	and	dehydı	ation			+	
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Sox 68760, death certificate be exe te attending physician a for use as the burial -		23b. Was decedent p past 12 months?		1 Live bi	rth	a af da ath	₂ Fe	tal death	3 [Ectopic pre	gnancy		Month	Day	Year
Box ne death the atte	≥L	1 Yes 2 N		own 9 Unkno	wn			her (Spec							
P. P.	۵	Part II. Other signif	icant conditio	ons contributing to	death bu	ut not resultin	g in the u	ınderlying	cause g	iven in Part I.			o use contribut ✓ No 3		ause of death? 4 Unknown
ords, w requir	pleted						_	•			24a. W	as an			findings available etion of cause of
tal Reco	Completed										1 🗸 Ye	erformed?		h? Yes	2 No
ing Physician: The Ling Physician: The Ling Physician: The Ling Physician and Affer this certificate Innertal director, page	8 2	25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital: 1 Ir	patient	2 Y ER/O	utpatient			of Death (Che	rsing Home 5	Resid	ience 6 C	Other:	
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lvision or Attend after death Director:	Certification:	2 Accident 3 Suicide	Invest	igation	of Injury	- At home, fa	arm, stree	et, factory,					and Number o	r Rural Ro	oute Number, City
Di Hospital 424 hours a Funeral I	Cert	4 Homicide	determ	nined (Specify)							60 fil	n, State)			
Division To the Hospital or Attence within 24 hours after death To the Funeral Director: Completely filled in by the	edical	(Check only	ledical Exam	vsician: To the best liner: On the basis of and manner sta	f examina	owledge, dea ation and/or i	ath occuri nvestigati	red at the ion, in my	time, da opinion,	te and place, a death occurre	and due to the c ed at the time, da	ause(s) a ate and p	nd manner as lace, and due t	stated. the cau	se(s)
	ž	29b. Signature and t	itle of certifier	1				29c	O.C.N	number			Date signed	(Month, Da	ay, Year)
PEND	-	Yunul 30. Name and addre	6s of person v	Kall MA) who completed cause	e of death	n (Item 23a)			U.U.IN	n. L.		Jul	y 9, 2010 —————		
		Pamela E. S						const.	Street	, Baltimore	, MD 21201				
Sta Registr	_	31. Date filed (Month	1 3 201	O Senew		Signature	arth								

		•	For State Registrar		State of N	larylan	d / Depa	artment of H tificate of D	eaith an eath	d Mental Hy	/giene Reg. No		22223
	Physicia		1. Decedent's Name Mar		Cind	ric				2. Date of D Month June	eath 2 7	2010 Year	3. Time of Death 4:30 P M
	Medic Examin		4a. Facility Name (if r	not institution, give s	treet and number)			4b. City, Town, or		eath		County of Deat	
تعديب	Funeral		5. Social Security Nu	t Hospice	7. A	ge (In yrs. Ia	ast birthday)	Towso	If Under 24 I			9. Birt	hplace (State or Foreign
	Director		212-42-5352 Usual Residence of I	1] M 2 🔀 F	66	Yrs.	Months Days	Hours N	Min. Februar	gy, 6°, 1	1944 Man	"Y Tand
	show dat	ř	10a. State	10b. County		10c. City	y, Town or Loc	cation					10d. Inside City Limits
:	e Mary r 28a-f notifie	Jirec	Maryland	Frederick		Mt.	Airy	10f. Zip Code			10.0		1 Yes 2 X No
:	with the 23a or 1st be	Funeral Director	10e. Street and Num 708 N. Warf					21771			USA	itizen of What Co	untr y ?
:	death items ner mu		11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S	3. 13. V	Vas Decedent of His f Yes, specify Cubar	panic Origin?	? (Specify Yes or No uerto Rican, etc.)	-	14. Race - Ame	
036	s after ral", or Exami	ed by	1 ☐ Never Marrie 3 【 Widowed 4		1 ☐ Yes 2X If Yes, Give Year or Dates.] No	1	☐ Yes 2 🔀 No	Specify:		1	Specify: Whi	
2-0	2 hour "natur edical	Completed	(Spec	15. Decedent's Ed			Give I	ient's Usual Occupa kind of work done du	tion uring most of	working	16b. K	Kind of Business	Industry
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nd i	e filed v tal Hyg ed othe event,	To Be	17. Father's Name (F		17					Name (First, Middle		Surname)	
aryla:	ould be nd Men marke imatic			ward Mitche me/Relationship (Typ			19b. Mailir	ng Address (Street a		Phyllis r Rural Route Numb		r Town, State, Zir	Code)
ž,	nd 2 sh ealth ar n 27 is ier trau		Katie Cindr	cic- daughte				ildmann Mill					
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortants if time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2	Cremation 3 🗆	Removal from Stat	e c	emetery, cren	sition (Name of natory or other place		Date ne 29, 2010	1	ocation - City or n Burnie,	
altin	mit. Pa partme portani r injury	13	4 ☐ Donation 21. Signature of Fun	5 Other (Specify	e		antic Cr	Name and Address	_		Grea	ii burine,	THI YICINI
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		8 2	shock, or hear Immediate Cause (F		e cause on each li	ne.				diac or respiratory a	irrest,		Approximate Interval Between Onset and Death
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3760	ficate to g physias the t	Aedical			d				•••				
Box 68760	eath certific attending p	ian/I	IF FEMALE: 23b. Was decedent of in the past 12 p	nonths?	3c. If yes, outcom	2 Feta	al death 3	Ectopic pregnancy	/		1	23d. Date of de Month	livery Day Year
. Bo	the dea by the a ached f	Physician/M	1 Yes 2 9 Unknown	No	4 ☐ Pregnant 9 ☐ Unknowr		death bil	Other (specify)					
Division of Vital Records, P.O.	To the Hospital or Attending Physicians: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit	by	Part II. Other signifi	icant conditions co	ntributing to death	but not res	sulting in the u	inderlying cause give	en in Part I.				the cause of death?
ords	requir been s should	Completed								24a. Wa	s an	24b. Were au	topsy findings available
Rec	sician: The law certificate has b lirector, page 2 s	Somp								per	opsy formed? 2 D N	death?	completion of cause of
ita	sician: certific rector,	Be	25. Was case referre examiner? 1 Yes 2		lospital:			Otho		Check only one)		- Thu 10	v. Hanning
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sion	ttendir death. stor: Af / the fu	Certificate;	2 Accident 3 Suicide	Investigation 6 Could not be	28e Place of I	nium, - At ho	ome farm str		Yes 2 No		/Street or	nd Number or Ru	ral Route Number,
Divi	tal or Ars after al Direct		4 ∐ Homicide	determined		tc. (Specif)				City or To	wn, State	e)	
	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2		er: On the basis of	examination	n and/or invest	tigation, in my opinio	n, death occur	rred at the time, date	and place	e, and due to the	cause(s) and manner stated.
:	To the within To the comple	Σ	only one) 3 29b. Signature and t	Certifying Nurse	Practioner: 10 tr	ie best of m	y knowledge, c	29c. License	number	d place, and due to	29d. Da	ate signed (Monti	n, Day, Year)
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	106		Lynn D.	Alonso,	ompleted cause of 0.5 , 89	ss 6	uilfor	d Road,	Suite 1	40, colu	mbi	a. Hary	land 21046
	Stat Registra	te	31. Date filed (Month	JUN 3 0 20	32. Rygis	trar's Signa	ture A.	backer					n, Day, Year) 2010 , land 21046

10-04716 Stephen Leonard Coh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 2224

Physician/	1.	For State <u>gistrar</u> Decedent's Name (First, Middle,Last)		ificate of D			Mo	Reg. lete of Death onth Da ne 23, 201	av Year	3. Time of Death 0718 hrs
adical Examine		Stephen Leonard Coh	ley	- Ah	City Town	or Location of D		ie 23, 20 i	4c. County of Death	<u> </u>
	4	a. Facility Name (if not institution, give stree South of Chestertown Yacht C		ı	Chesterto				Kent	
Funeral	5	Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	f Under 1 Ye	\rightarrow		ate of Birth (MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Funeral Director	1	215-62-0689 1XM	2_F 56	Yrs.	Months Da	ays Hours	Min.	3/7/19	00	ountry) MD
ny .	_	sual Residence of Decedent Da. State 10b. County	10c. City, 1	Town or Location						10d. Inside City Limits
D 00 0		MD Queen Anr	ne's Che	estertow	n					1 Yes 2 X No
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. ant: If item 27; marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once.	1	De. Street and Number	3.0		Of. Zip Code			10g.	Citizen of What Cou	ntry?
the Man or 2	[6402 Church Hill Ro	ad		2162	20			USA	i Indian Diook
r death with the or items 23a	1	Marital Status 12.	Was Decedent Ever in U.S Armed Forces?	3. 13. Was E	ecedent of I specify Cub	Hispanic Origin? pan, Mexican, Pu	? (Specify ` uerto Rican	Yes or No- n, etc.)	White, etc.	rican Indian, Black,
death or ite	5	Never Married 2 X Married	Yes 2 X No	1 7	es 2XII	No specify:			Specify: Wh:	ite
s after ral", nincr	<u> </u>	Widowed 4 Divorced If Yes or Div		16a Decedent's	Usual Occur	pation (Give kin	d of work d	lone 1	6b. Kind of Business	/Industry
"natu	<u> </u>		College (1-4 or 5+)	during most	of working l	ife. DO NOT us	e retired)			
5-0036 ed within 7/ Tygiene. other than	Collibleted	12		Waterm	an				Seafood iden Surname)	
5-003 led withir Hygiene other th		7. Father's Name (First, Middle, Last)								
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical		Leonard Mason Cohe 9a. Informant's Name/Relationship (Type,		19b. Mailing A	ddress (St	reet and Number	r or Rural l	a Owen	er, City or Town, Stat	e, Zip Code)
MD 21 ad 2 should lith and Me m 27 is ma aumatic cv	١,	Christina C. Cohey				Hill Ro		hester	town, MD	21620
and 2 lealth tem 2 traun	ŀ	20a. Method of Disposition	20b. F	Place of Disposition	on (Name of	cemetery,	Dat	e 2	20c. Location - City of	r Town, State
Ore ages l at of F t: If i	- 4	1 X Burial 2 Cremation 3 F	temoval from State	umpton C		rv	6/28/	2010	Crumpton.	MD
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other traumantic event, the Med injury or other traumantic event, the Med	-	Other Specify: Other Specify: Signature of Funeral Service Licensee	./ /	Fe I	ne and Addr	ess of Facility Helfen	bein	& Newn	am Funera	1 Home
De Perr	1	Kungful	Into	130	Snee	r Rd. Cl	heste	rtown.	MD 21620	Approximate Interval
Physician	7	23a. Part I. Enter the disease, or complicati failure. List only one cause on each li	ne.	Do not enter the	mode of dyl	ng, such as care	ulac or resp	on alory arros	, 5/1001, 5/1/22/1	Between Onset and Death
≥xaminer			wning to (or as a consequence o	f)·						
-		h	to (or as a consequence o	···						
	힐	Sequentially list conditions, if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence o	f):						
	Examiner	in the second second	to (or as a consequence o	f):						
Box 68760, he death certificate be executed y the attending physician and thed for use as the burial - transit	<u>~</u>	d								
be exe	edical	ON EMPER	MENDED						23d. Date of delive	erv ————
876C ficate g phys s the b	≝[3b. Was decedent pregnant in the	3c. If yes, outcome of preg		il death	3 Ectopic p	oregnancy		Month	Day Year
30x 6876(death certificate e attending phy.	sician/M	past 12 months?	Pregnant at time of de	eath 5 Othe	er (Specify)				l .	
Bo ne deal	Phys		Unknown	esulting in the un	iderlying cau	se given in Parl	il.	23e. Did tob	acco use contribute	to the cause of death?
cords, P.O. law requires that the has been signed by 2 should be detach	3	Part II. Other significant conditions	idibating to down be				_	1 Yes	2 No 3 P	robably 4 Unknown
ds, l	lg e			_				24a. Was a		autopsy findings available o completion of cause of
COFC law re has be	Completed							perform	ned? death	?
certificate		25. Was case referred to medical			26.P	Place of Death (Check only	one)		
/ital	o Be		pital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other ₄	Nursing H		Residence 6 🗸 Ot	her: Scene
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	H١	27. Manner of Death	28a. Date of Injury FOUND:	28b. Time of In FOUND:	jury 28c.	Injury at Work? Yes 2	Sul	d. Describe h bject fell c	ow injury occurred out of boat into r	iver
ion itendii leath. tor: /	aţio	1 Natural 5 Pending 2 ✓ Accident Investigation	Jun 23, 2010	0718 hrs	feeten off			Location (S	treet and Number or	Rural Route Number, City
ivis or At after of Direc	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I	nome, rarm, stree	t, lactory, on	ice building, etc	- 1	or Town, St	ate) Chestertown, MD	
Divis Hospital or A 24 hours after Funeral Dire		4 Homicide	To the heat of my knowled	dge, death occurr	ed at the tim	ne, date and place	ce, and due	e to the cause	e(s) and manner as s	stated
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On	the basis of examination at manner stated.	and/or investigati	on, in my op	inion, death occ	curred at the	e time, date a	and place, and due to	7 110 04450(0)
To with To con	Mec	29b. Signature and title of certifier	A Marino Stated.			cense number			29d. Date signed (
15		(aure A)	allan	-).C.M.E. 			June 24, 2010	
,		30. Name and address of person who con		_{m 23a)} 111 Penn S	Street Pa	Itimore MD	21201			
Tm			Medical Examiner		oreet, ba		21201			
St	ate	31. Date filed (Mon UN 28 201	32. registrar's Signa	D. 494						

amended item #1 7/2/10 wchd map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Nagre (First Middle, Last) 2. Date of Death Day 29 Ann Shorley Clark 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Medical SAUSBUL. Centa TENINSULA BOGIONAL (con/E . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🛱 F Months Days Hours Min 08-17-1944 Maryland 219-42-9045 65 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 X No Bridgeville Delaware Sussex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19933 U.S.A. 16514 Progress School Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Benvita Sutiliff William C. Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16514 Progress School Rd., Bridgeville, DE 19933 Raymond Irving Clark/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eastern Shore
Crematorium 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-06-2010 Lewes, Delaware 22. Name and Address of Facility al Homes & Crematorium 202 Laws Street, Bridgeville, DE 19933 21. Signature of Fig. 31 Service Lice see M00866 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final 0 Car disease or condition resulting in death) Due to (or as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Day Month Year 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🗷 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 K Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury ■ Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number,

: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Baltimore, Maryland 21215-0036 permit. Page 1
Department of I
Important: If it
any injury or o Physician/ Medical Examiner Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearh.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Division of Vital Records, P.O. Box 68760 Completed by Be (ဂ္ Certificate: 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D46536 6/29/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 MIR State

Registrar

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32. Engistrar's Signature

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Physician/

Medical

Director

Funeral

Completed by

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Examiner

Funeral

Director

SAlisbury

Md. 21801

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 201th **Physician** M Ann Chapis Mary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Denton 11231 River Road 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Country) Illinois Hours Min 1 □ M 2 🖾 F January 28, 1920 361-05-1350 Director 90 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural" or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Examinational Beautified at another. 10b. County 10a. State 1 TYes 2K No Director Denton Maryland Caroline 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UnitedStates of America 21629 11231 River Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2**X**If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 X No Maryland 21215-0036 1 ☐ Yes 2X No ^{Specify:} Caucasian ≥ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home/Barber Homemaker/self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victoria Thomas Pando Simon ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8057 Hearns Pond Road, Seaford, Delaware 19973 Son John G. Chapis Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State Dover, Delaware 7/8/2010 Capitol Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one carry on each line. Immediate Cause (Final CARDIAL INPARCITION Physician ACUTE Die to (or as a consequent of disease or condition resulting in death) /Medical ARDIOVASCULAR DISCOR CHRONIC Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, physician the use as attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ♠ No 5 Other (specify) detached 9 D Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deatl filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co M.D., PO Box 690, Denton, Maryland Jensen, Christian E. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu JUL 08 2010

DHMH 17 Rev 1/2001

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 22227 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Patricia Lee Conrad June 2010 26 P^{M} 2:35 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 55 Manor Dr. Apt 101 Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Days Hours 220-64-0276 Yrs Director Jan. 8,1953 57 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be mutthed at 1 XYes 2 □ No Be Completed by Funeral Director Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 Manor Dr. Apt 101 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 10 Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Embrey Wilburn Merile McLamb Wilburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any Injury or other trau Martin Conrad-husband 55 Manor Dr. Apt. 101 Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6-30-2010 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Douglas A. Fiery Funeral Home licentes 1 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** vears a chronic obstructive pulmonary disense /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FÉMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 C Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ea Kuttrer- Sands, no June 28, 2010

WF 3

Registrar
DHMH 17 Rev 1/2001

State

Kuttner Sands and Hospice of Washington County

32. Registrar's Signature

747 Northern Avenue

Maryland 21742

Hagerstown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Walter Marshan Deaton Physician/ June ^D2^y2 2010 13:35 pm Medical a. Facility Name (if not institution, give street and number)
Southern MD Hospital Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton, Prince George's Co 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Country 1 🛛 M 2 🗆 F Days 1/Month 25, Year 0 218-72-1559 49 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director Prince George' Capital Heights X□ Yes 2 □ No MD 10e. Street and Number 10g. Citizen of What Country? 1414 Pacific Avenue USA 20743 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Hair Stylist 15. Decedent's Education 16b. Kind of Business Industry
T.C. International (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salon 12th years Be 18. Mother's Name (First, Middle, Maiden Sumame)
Beatrice Douglas 17. Father's Name *(First, Middle, Last)*Walter Deaton ပ္ 19a. Informant's Name/Relationship (Type, Print)
Beatrice Sisco W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7680 Airy Hill Rd. Chestertown MD 21620 Möther Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, St. Churchill MD Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Bethel Cemetery 6/26/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Bennie SmithFH 855 High St.Chestertown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ps disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.

France of Pour Street of Physician; The law requires that the death certificate be executed 1. Funeral Director, After this continues. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 28c. Injury at 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 29b. Signature and title of certifier 5

Registrar
DHMH 17 Rev 7/2009

State

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 22229 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 23 Thomas M. Drowsky 06 2010 09:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Golden Living Center Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MARYLAND Days 1XX M 2 □ F Months 218-12-0829 86 Director Usual Residence of Decedent or 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 28 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PA York Hanover 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 87 Country Lane 17331 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: 3XX Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Iron Worker Manufacturing Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ဂ Mabel Unknown <u>John Drowsky</u> 1 and 2 should be Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Westview Drive, McSherrystown, PA 17344 Matthew A. Drowsky/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Kenworthy Funeral Home, Inc. 06/24/2010 Hanover, PA 17331 21. Signature of Fundral Service Licensee 22. Name and Address of Facility 269 Frederick Street Kenworthy Funeral <u>Home, Inc., Hapover PA 17331</u> 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition nset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy ō in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Jas autopsy performed? Yes 2 🖎 N director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural injury 5 Pending 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

P.O. Records, of Vital Division

> WIL 10

(Check only one)

29b. Signatura

and title of certifie

Registrar

State

who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed Month, Day, Year,

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 June 30, Physician/ 6:25 a M Carol Sue Dean Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Kensington Montgomery 9914 Wildwood Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days 1 M 2 1 F Months Hours Nov. 5 Year 1943 D.C. 213-48-3790 66 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b County 10c. City, Town or Location 10a. State death with the Maryland Director 1 ☐ Yes 2 🕇 No Maryland Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 ms 23a or must be n Funeral USA 9914 Wildwood Road 20895 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, ıral", or iten I Examiner ı Armed Forces?

1 Yes 2 No Black, White, etc þ 1 X Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Never Worked Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any linjuy or other traumatic even once. Dorothy E. Mace Nicholas Oliver Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9914 Wildwood Road, Kensington, MD 20895 Dorothy M. Dean/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date July 2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22 Name and Address of Eachity Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Years Immediate Cause (Final Arteriosclerotic Heart Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 20 years Type I Diabetes Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Exam physician and the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be exect thin 24 hours after death. Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: . nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by þ Grand Mal Seizure Disorder 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? ate has page 2 s certificate Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{\frac{\mathbf{N}}{2}} \) Residence \(6 \) Other (Specify) 1 Tes 2 🖰 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident within 24 hours after death

To the Funeral Director: ,
completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) certifier 29c. License number ρ D09577 June 30, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Richard Pollen, MD

31. Date filed (Month, Day, Year)

🕉2. Registrar's Signature

10400 Connecticut Avenue, Kensington, MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav 9:10 A M **Physician** Forrest P. Deneau 30, 2010 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Caroline Home for Hospice Denton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) July 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months 1937 Maryland 72 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Preston Director MD Caroline 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ö United States 21655 22272 Havercamp Road 23a Funeral items ? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 6 1 ☐ Yes 2 Z No Specify: Specify: White þ 3 Nidowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) State Highway than, Elementary/Secondary (0-12) College (1-4or 5+) Shop Supervisor d 2 should be filed w. th and Menta! Hygier 7 is marked other th Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be V. Nellie Trice Forrest Edward Deneau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 22272 Havercamp Road, Preston, MD 21655 partment of Health ai cortant: If item 27 is injury or other trau L. Dawn Deneau/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cemetery 07/03/10 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Michael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final month Physician ancrea disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown ArCEry page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director; After this certifica 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (S 1∐Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature a D0053815

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

(MOOD)

JUL U 2 201

D Market Street Wenton MD 2/629

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 26 per Phy. 06/29/2010 Carroll Co., will
State of Maryland / Department of Health and Mental Hygiene 0 | 0 22232 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0422M 2010 Virginia Elmore June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. Date of Disc. (Month, Day, Ye 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday Funeral Country) 1 - M 2 - X Hours 94 Director lune 1916 234-50-8662 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
i item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 X No WV Roane Spencer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25276 USA 37 Oak Drive Addition Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give 1 ☐ Yes 2 XXIo Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Leona Hester Keen George Henry Hunt, Sr. permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 2409 Deer Park Road Finksburg, MD Sondra E. Reger 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Clover Cemetery 1XXBurial 2 Cremation 3 Removal from State July 3,2010 Clover, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD nt 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, oct, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ⊳Physician/ accident Ceravascula disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown sate has been signed by the a page 2 should be detached it Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 200 Other: 1 Inpatient 2 K ER/Outpatient 3 IDOA ■ 5 Residence 6 Other (Specify) 유 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature a WJL 2+8 dress of person who completed Pole Rd Westminster, MD 21157 iddleton 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records.

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 0 1 0 22233 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 0942 **Blanche** B. Elliott 1, 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Salisbury Rehabilitation + Nursing Ctr. If Under 1 Year 5. Social Security Number 24 H 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 💢 F Months Davs Hours Min. 220-09-1180 7-18-1912 North Carolina Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 1514 Riverside Drive, A202 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Textile Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Church Sallie John McNeil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 May Drive, Madison, Tennessee 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Springhill Memory Gd: 7-6-2010 Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home Kell 705 E. Main Street, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death Toras ears Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3

Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 □ Yes 2 1No 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760, signed I funeral director, spita. + hours after of filled in 24 hours

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Physician

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0036

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn any Injury or other traumatic event, Ite Medical once. Ronald Elliott - Son 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on a cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed 25. Was case referred to medical Be 1 ☐ Yes 2 ☐ 1√10 Certification: To 27. Manner of Death 1 - Natural 2 Accident 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Robins, 200 Civic Ave., Salisbury MD 21804 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JUL 0 2 **201**0 Registrar **ORIGINAL**

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physician/	,	1. Decedent's Name (First, Middle									2. Date of Dea	ath		Year	3. Time of Death	
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Examine	r	ANNE ARUNDEL ME					4b. City, T	POLI		of Death				y of Death ARUN		
Funeral		5. Social Security Number	6. Sex	7	. Age (In yrs. I	ast birthday)	If Under	1 Year		r 24 Hrs. Min.	8. Date of Birt	th		9. Birtl	place (State or Foreig	gn
Director	-	478-54-1430 Usual Residence of Decedent	1 LI N	1 2 X F	64	Yrs.	WOITE	Days	nours	IVIII1.	APRIL 6	, 19	46	<u>I</u> o	WA	_
show and	5	10a. State 10b. County			10c. Cit	y, Town or Loc	ation								10d. Inside City Limit	s
Maryla 28a-f	Director	MARYLAND QUEEN	ANNE	'S	GRAS	SONVILL	E								1 🗆 Yes 2 🗶 N	40
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or ite	D.	1 Never Married 2 X Marr	- 1	Armed Ford	es? 2 🗶 No	If	Yes, specif	y Cuban,	Mexica	an, Puerto	Rican, etc.)			ce - Amer ick, White	ican Indian, etc.	
urs aft tural",		3 🗌 Widowed 4 🗆 Divorced		If Yes, Give Year or Date		1	Yes 2	No No	Specify	y:		5	Specif	WHIT	E	
72 ho n "nat fedica	Completed	15. Deceder (Specify only highe	nt's Educa st <i>grad</i> e c	tion completed)			ent's Usual ind of work NOT use i	done dur		st of work	ing	16b. Kir	nd of E	Business I	ndustry	
within siene.		Elementary/Seconday (0-12)		College (1-4	l or 5+)	CONSU						CONS	ULI	TING		
	10 Be	17. Father's Name (First, Middle, L	ast)								ne (First, Middle,	Maiden S	urnan	ne)		
d Men d Men marke matic	-	DONALD WALLACE 19a. Informant's Name/Relationsh	in Time	Print)		101 11 11			-		DHURST		-		0.11	_
d 2 sho alth an 27 is r trau		JAMES FROST/HUS		,							al Route Numbe. GRASON				LAND 21638	3
of Hero of Hero fitem rothe	Ì	20a. Method of Disposition			20b. F	Place of Dispos	sition (Name	e of			Date				Town, State	
. Page Iment tant: I jury o		1 Burial 2 X Cremation 4 Donation 5 Other (S		noval from S	CHE!	SAPEAKI	EREN	IATIO	N	JUNE 2010	029	STEVE	NS	VILLE	, MARYLANI	O
Departition Depart		21. Signature of Funeral Service L	icensee	1		- FEI	LOWS	Addres	FEN	BEIN	& NEWNA	AM FU	NE	RALE	OME P.A.	
	\dashv	23a. Part 1. Enter the disease, or	complica	tions that ca	used the deat						CHESTER or respiratory arr		IKI	LAND	Approximate	
hysician/		shock, or heart failure. List of Immediate Cause (Final				i e		, , , , ,			, , , , , , , , , , , , , , , , , , , ,	,			Interval Between Onset and Death	
Medical		disease or condition resulting in death)	a	Due to (o	r as a consequ	uence of):										
Examiner	.	Sequentially list conditions,	b		Peri	ton i-	his.									
and -transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury		Due to (o	as a consequ		000-	1.								
in and ial-trar	- 1	that initiated events resulting in death) Last	с	Due to (o	r as a consequ	_	010	no~								
If the deam certificate be earlied to the attending physicia stached for use as the buri	5		L d.								· ·					
ding place as t	MAC	IF FEMALE:	230	If yes outco	ome of pregna	incv										
atten	5	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	200.	1 Live B	irth 2 Feta ant at time of a	al death 3	Ectopic pr					2		ate of deli onth	very Day Year	
by the a tached for	<u> </u>	g 🗌 Unknown		g Unkno												
es tra	≥	Part II. Other significant condition	ons contrib	outing to dea	ath but not res	sulting in the ur	nderlying ca	ause giver	n in Parl	t I.					the cause of death?	
been sign	ומום				,						1				opsy findings available	
sate has been si page 2 should t												osy rmed?	Z4D.	prior to c death?	ompletion of cause of	3
clan: The certificate bector, page		25. Was case referred to medical						26. Plac	e of Dea	ath (Chec	l 1 ☐ Yes k only one)	2 - N 0	<u> </u>	1 ∐ Yes	2 No	
his cer I direc	2	examiner? 1 Yes 2 No	Hos	oital: 1 اللغة	patient 2 🗆	ER/Outpatien	3 🗆 DO	Other:	4 🗆 N	Jursing Ho	ome 5 🗆 Resid	dence 6	☐ Oth	ner (Speci	(y)	
eath. or: After this the funeral d	916	27. Manner of Death 1 Natural 5 □ Pendin	g	28a. Date of (Month	f injury , <i>D</i> a <i>y</i> , Ye <i>ar</i>)	28b. Time of injury		c. Injury a		٦	28d. Describe h	now injury	occur	red		
or Attending Praffer death. Director: After t in by the funera		2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be	28e. Place o	of Injury - At ho	ome, farm, stre	M et, factory,	1 \(\superstack \text{Ye}\) office	es 2L	_l No	28f. Location (S	Street and	Numl	ber or Run	al Route Number.	
s after or all Direction by the second of the second or all Direction by the second or all Di		4 - Hornicide determine	ined		g, etc. (Specify						City or Tow					
to the Prospital or Attending Proysician: The law requires that the death Certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Maclinal Certificate. To Re Completed by Divisional Maclinal Evami		(Check 2 L Medical E	xaminer:	On the basis	of examination	n and/or investi	gation, in m	y opinion,	death c	occurred a	nd due to the car	and place.	and di	ue to the c	ause(s) and manner sta	ated.
vithin 2	- 6	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Pr	actioner: To	the best of m	y knowledge, d		ed at the t License n		te and plac	ce, and due to the			nanner as :		
- > - 0		D		Mari	tom		/	100	28	44	5	01	9/	24/	2010	
163	ł	30. Name and address of person	who comp	eleted cause	of death (Item	23a) (Type, P	(m) 1	,)	<u>ن ر</u> ر	1	Λ),		/	1	20032	_
,		31. Date filed (Month, Day, Year)	V(-1	1))(gistrar's Signa	00/	5101	1/1		100	117	14)6	06	10 7	INV	_
State Registrar		JUL - 1	2010	Day	www /	J. pa	New									

Registrar DHMH 17 Rev 7/2009 Funer Direct

			Please	State of						-				2235
	1	For State Registrar			····ai y rai i	_	tificate				Reg. No		ں ک	2200
Physician Medica	1/	1. Decedent's Name Walter	r E. Giv							2. Date of De June 2		10 Ye		Time of Death
Examine	_	4a. Facility Name (if i			r)			wn, or Locat	ion of Death		40	County of D		
Funeral Director		5. Social Security Nu 212-30-13		Sex 7. 1 [X] M 2 □ F	Age (In yrs. Ia 79	st birthday) Yrs.	If Under 1		nder 24 Hrs.	8. Date of Bir	th Y Y973	g.		State or Foreign
	_ h	Usual Residence of I	Decedent 10b. County		10c City	, Town or Lo	cation						10d In	side City Limits
28a-f st otified	irecto	MD	Queen A	nne	1 '	vensv								Yes 2X No
s 23a or ust be n	Funeral Director	10e. Street and Num 1233 Lov	_{ber} ve Point	Road			10f. Zip C	ode 1666			-	itizen of What ISA	Country?	
amin .	۾	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Deceder Armed Force 1 🖾 Yes 2 If Yes, Give Year or Dates	^{s?} □ _{No} Korea		Vas Deceder f Yes, specify	Cuban, Mex	dican, Puerto I	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	hite, etc.	_{lian,} hite
an "natu Medical	Completed	(Spec	15. Decedent's cify only highest g	Education rade completed) College (1-4 d	or 5+)	(Give I	lent's Usual (kind of work (O NOT use re	done during r stired)	most of workii	ng	Ī	Kind of Busine		
Hygiene the	a F	07 17. Father's Name (F	7 ^ _			-	———		fother's Name	e (First, Middle,		e Impr	oveme	nt ————
Mental arked c	2	Howard								ndjean	ivialueri	Surname)		
alth and h		19a. Informant's Nar Flora Gra			e					Route Numbe Stevens				6
ant: If iten		20a. Method of Dispo 1 ☐ Burial 2 ∑ 4 ☐ Donation		Removal from Sta	ate AtÎ	lace of Dispo emetery, cren antic	sition (Name natory or othe Crema	of er place) tory	06/30) _{ate} /2010		ocation - City n Burn		tate
Departr Imports any inju		21. Signature of Fundament	Service Lice	ised		22 F	. Name and A	Address of Fa ty Fun	acility eral H	ome P.A	4. Å	2 Ridg nnapol	ely A	ye D 21401
ysician/		23a. Part 1. Enter the shock, or heart Immediate Cause (F	t failure. List only	nplications that causone cause on each	sed the death line.	n. Do not ente	r the mode o	of dying, such	n as cardiac o	r respiratory an	rest,		Inter	roximate val Between et and Death
Medical xaminer		disease or condition resulting in death)	•	Due to (or a	asa consequ	ence of):								
sit	Examiner	Sequentially list con if any, leading to immoduse. Enter Under	mediate lying	b. Due to (or a	as a consequ	ence of):								
- ri a	= 1	Cause (Disease or ii that initiated events resulting in death) L		Due to (or a	as a consequ	ence of):								
nding phy use as the		IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outcor	ne of pregnar	ncy	1					23d. Date of	delivery	
y the atteached for	hysicia	in the past 12 m 1 Yes 2 1 9 Unknown		1 Live Birt 4 Pregnan 9 Unknow	t at time of d		Other (spec					Month	Day	Year
n signed build be deta	≥	Part II. Other signific	cant conditions	contributing to deat	h but not resu	ulting in the u	nderlying cau	ise given in F	Part I.		/	use contribute		se of death?
ate has be	Completed											prior death	to completi	ndings available on of cause of
certifica rector, I	Re	25. Was case referred examiner? 1 Yes 2.	^	Hospital:				Other:	Death (Check	only one)				
ith. After this funeral di	cate: lo	27. Manper of Death 1 Natural 2 Accident		28a. Date of i (Month, i	atient 2	ER/Outpatien 28b. Time of injury	-	Injury at work?		me 5 Residence 128d. Describe h		Other (S) y occurred	pecify)	
s after deg	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	28e. Place of	Injury - At hor etc. (Specify)		et, factory, o	ffice	2	28f. Location (S City or Tow			Rural Route	e Number,
n 24 hours ne Funera pleted fille	Medical	29a. Certifier 1 (Check 2 only one 3	Medical Exam	ysicían: To the best niner: On the basis o rse Practioner: To t	f examination	and/or invest	igation, in my	opinion, deat	th occurred at	the time, date a	and place	e, and due to t	he cause(s)	and manner stated.
To th		29b. Signature and ti	itle of certifier					icense numb			29d. Da	te signed (Mo		
473		30. Name and addre	ss of person who	completed cause o	f death (Item	23a) (Type, P	rint)	Cul	310	Amie	di	MO		401
State Registrar		31. Date filed (Month)	JN 3 0 20	32 Regis	strar's Signatu	ire de	W.	10110				. (-		
	_			4	,	-								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:00 PA M Brian Keith Physician/ Month Jun Geiman 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1522 Hughes Shop Rd Carroll Westminster If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 🗹 M 2 🗆 F 5 Director 219-60-3656 Dec. 6 1950 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Carroll 1 Yes 2 X No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 1522 Hughes Shop Rd. 21158 U.S.A. Was Decedent Ever in U.S. Armed Forces? 1974−1 Pres 2 No 1978 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 1978 Specify: White 3 Widowed 4X Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) rtal Hygiene. ed other than " event, the Me Elementary/Seconday (0-12) Delivery Driver Carroll County Foods Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred P. Myers Edward Preston Geiman 19a. Informant's Name/Relationship (Type, Print)
Jeffrey Geiman - Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 Hughes Shop Rd., Westminster, MD 21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cem. 6/25/2010 Westminster, MD . Signatu of Fun Selvice Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and earl Immediate Cause (Final Pancreatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on) as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury and that initiated events Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 LNo Yes 2 1 Yes the funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital: 2 110 Other: 1 Tes <u>|</u>2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at s after death. I Director: After t Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital within 24 hours a To the Funeral C Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 0A12+1 31. Date filed (Month, Day, Year)

Registrar

			For State	State	of Maryland		artment of F rtificate of		d Mental Hy	giene	010	22237	
			Registrar 1. Decedent's Name (First, Middle	e, Last)			tineate or	Dealii	2. Date of De		010	3. Time of Death	
	Physicia		E	dna Mary	v Glass				June 2	7 . Day	1010 Year	12:00 A ^M	
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of De			ounty of Deat		٦
			Golden Livin	g Center	2		Westmi				rroll		
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🔽 F	7. Age (In yrs. la		If Under 1 Year Months Days		8. Date of Bir (Month, Date)	th ly, Year)	9. Birt	thplace (State or Foreign ountry)	
	Director		162-26-5285 Usual Residence of Decedent	TESWI ZUPET	78	Yrs.			6/25/1	932	Gett	ysburg, PA	A
	land ow		10a. State 10b. County	1.1	10c. City,	Town or Lo	cation					10d. Inside City Limits	\exists
	Mary a-f sh fied a	żo	MD Frede	rick	E	mmits	bura					1 ☐ Yes 2 PNo	
	or 28%	Jirec	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	ountry?	٦
	tth wil	ral	10928 Keysvi	lle Road	E		217	727		U.S	. A .		
	tems	Funeral Director	11. Marital Status	Armed F	edent Ever in U.S orces?	. 13. \	Was Decedent of H f Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	? (Specify Yes or No Jerto Rican, etc.)	- 14	 Race - Ame Black, White 		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	led 1 ∐ Yes If Yes, G Year or [2 No ive		I□Yes 2♥No	Specify:		s	Specify: Wh	.ite	
Maryland 21215-0036	thou		15. Decedent	's Education		16a. Dece	dent's Usual Occup	oation		16b. Kind	d of Business/	/industry	\dashv
215	hin 7%	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College ((Give life. I	kind of work done OO NOT use retire	during most of i d)	working				
7	d with	Con	12			Home	maker				n Hom	e	_
2	be file tal Hy d oth	Be (17. Father's Name (First, Middle,	_				18. Mother's N	Name (First, Middle	, Maiden Sı	urname)		
<u>Y</u> a	should be f and Mental I s marked of tumatic eve	10	George Si						ie McCac				
<u>a</u>	12 sh h and 7 is m traum		19a. Informant's Name/Relations		, ,		•		r Rural Route Numb	-			
e,	s 1 and 2 should f Health and Men item 27 is marke other traumatic		David M. Glas	ss – nus		1 0 9 2 8	Keysvi		d. Emmit	Sbur 20c. Loca	g, MD ation - City or	21727 Town, State	-
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 Burial 2 ☐ Cremation		State		sition (Name of natory or other pla		/172010		erick		
Ħ	nit. Partme ortan injur		4 ☐ Donation 5 ☐ Other (S _i 21. Signature of Funeral Service.		Rest	22	MemC	ess of Facility					1
B	Dep Imp		Must R.	1 700	me) M	lyers-Du	rborav	V Funera	l Ho	me MD	21727	H
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the death						g, mu	Approximate Interval Between	
L	Physician		Immediate Cause (Final disease or condition	orny one cause L	w - K			(1)	sone	0.		Onset and Death	
	/Medical		resulting in death)	a. Due to	(or as a conseque	ence of):	HIEC Y	un	422			July - C	
	Examiner		Sequentially list conditions.	b									_
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseque	ence of):							
	execut and al-tran	Examiner	that initiated events resulting in death) Last	c	(or as a conseque	ence of):							-
8760	cate be executed physician and the burial-transit	dical E		d									
89	tificat ig phy as the	ledic		J									-
Вох	eath certific attending p	N/NE	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnan		Ectopic pregnanc			23	3d. Date of de		d
_•	ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 No		gnant at time of de		Other (specify)				Month	Day Year	
P.0	that the de ned by the detached	Phy	9 Unknown			ting in the u	adorlying souso giv	ion in Port I	23e Did	tohacco us	e contribute t	o the cause of death?	\dashv
g,	8 5 8	ρ	Part II. Other significant condition	ns contributing to t	Jean Dut not resul	ung in the ur	rderlying cause giv	ven in Fart i.	1 🗆	A.	/	robably 4 Unknown	
Š	w requir s been si should t	etec							_			utopsy findings available	\dashv
Vital Record	ne fav e has ge 2 a	Completed							— 24a. Was auto perfe	psy ormed?	prior to death?	completion of cause of	
g			25. Was case referred to medical	-				26 Place of I	1 ☐Yes Death (Check only	2 No	1 ∐Yes	s 2 No	
	ysicia is ceri	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2 🗆 E	R/Outpatier	nt 3 DOA Oth	ner:	ng Home 5 ☐ Res		☐Other (Spe	ecify)	٦
10	ding Phys h. After this funeral dir	T:U	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date	e of Injury oth, Day, Year)	28b. Time of	28c. Inju Woi		28d. Describe				
<u> </u>	teath. tor: Ai the fu	atic	2 ☐ Accident investig	ation				Yes 2 □ No					-
Division	200>	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	e. Plac	e of Injury · At hor ling, etc. <i>(Specify</i> ,	ne, farm, str	eet, factory, office		28f. Location City or To	Street and wn, State)	Number or R	lural Route Number,	
	pital		29a. Certifier 1 Certifyin	a Physician: To th	e heet of my know	ledge deat	h occurred at the t	ime date and n	place, and due to the	cause(s)	and manner :	as stated	-
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Medical		Examiner: On the					occurred at the time				
	To the within To th∉ compl	Me	29b Signature and title of certifier				29c. Licens	se number		29d. Date	7 /	th, Day, Year)	
	MJL		JAMIN .	4An	DO		H	005.2	5845	6/	28/2	010	
	W 3 0		30. Name and address of person	who completed cau	ise of death (Item	23a) (Type,	Print) / K	LING	SDR	IBE	1	1787	
	1,		KEVIN BI	EWS/	ETZ, Del),	TAK	DEVI	5 WN	Me	t. x	1787	_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ^{Day} 2010 Physician/ Ruth Eloise Gordon 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Vindobona Nursing Home Braddock Hgts 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) (Month, Day, Year) 9 / 1 2 / 1 9 1 1 Hours Min. 217-76-1572 Director MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c, City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Frederick Jefferson 1 Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21755 USA 5012 Holter Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilbur Samuel Gordon Estell May Riddlemoser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $5124\ Holter\ Rd.,\ Jefferson,\ MD\ 21755$ Doris Ott (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Permoval from State 4 Donation 5 Other (Specify) Reformed Cemetery 6/28/2010 Jefferson, MD e of Fur a Sa Toe Lior na 2D trail durant from pson Funeral Home POB 18, Middletown, MD 21769 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part 1. Enter Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Physician/Medical Examiner Due to (or as a consequence of): if any leading to immedicause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by llitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 Yes 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann P Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral 1 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 32073

Registrar

State

6109th

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Bases.

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Month **Physician** Catharine Stewart High 18 1:05 p ^M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 21, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 F 91 166-12-7861 1919 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

ther than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Westminster permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Mexical Examiner must be notified in Carroll 1 ☐ Yes 2 No Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 2351 N Old Bachman's Valley Road USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 white 1 ☐Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Publishing Co Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elvira Viola Baumgardner Ernest Wilbur Stewart, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2351 N Old Bachman's Valley Rd, Westminster, Barry C. High, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/22/2010 Westminster, MD Meadow Branch Cem 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 15 T لمر Approximate Interval Between Onset and Death 93a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner FECT ULCET? The law requires that the death certificate be executed Due to (or as a consequence of) burial attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 1 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 □Yes 2 ☑ No Hospital or Attending Physician; 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 🖪 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation n 24 hours after death. e Funeral Director: Aft eletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check o one) and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signatu treat Waster, MI)21157 State **JUN 23** Registrar

Emily Louise Herbane Activities (Free Herbane) Security			-	1 - State of Maryland / De State of Maryland / De	epartment of Health and N Certificate of Death	Mental Hygier	01050	22240
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	State of Maryland / D	epartment of He	alth and Mental Hy	giene	2010

		1- For State Registrar		rtificate of	Death		75 - R	eg. No.	22241
Physici edical Exami		1. Decedent's Name (First, Middle,Last) Muaide Munt					2. Date of Dea Month July 6, 20	Day Year 10	3. Time of Death 0518 hrs
		4a. Facility Name (if not institution, give 5705 Spinnaker Drive			Salisbury	r Location of Dea	ath	4c. County of Death Wicomico	
Funeral Director			7. Age (In yrs. I	last birthday) 17 Yrs.	If Under 1 Year Months Day			rth(MM/DD/YYYY) 9. Birt 14,1993 Foreig Cou	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once,	d by Funeral Director	Usual Residence of Decedent 10a. State MD Wicomi 10e. Street and Number 5705 Spinnaker 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only	Drive 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Ye	Sa 10f. Zip Code s Decedent of Hi es, specify Cuba Yes 2 No 's Usual Occupa	n, Mexican, Puer o specify: ation (Give kind o	Specify Yes or Noto Rican, etc.)	White, etc.	ates can Indian, Black, ian
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Baltimore, permit. Pages I an Department of Hea important: If iten		1 Burial 2 Cremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service License	Removal from State	crematory or oth nammad Buk	erplace) kas Cemete	ery 07/	08/10	Federalsbur	g, Maryland
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Physician /Medical Examiner			h line. langing		e mode of dying	, such as cardiad	or respiratory arr	est, snock, or neart	Approximate Interval Between Onset and Death
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	-	30 Name and address of person who co		•			201		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. N. 2010

		•	For State Registrar	State of Maryl		artment c <i>rtificate c</i>		and M		giene Reg. N	010	22242
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	The second secon					2. Date of Dea	ath Day	Year	3. Time of Death
	Medic			nan					July	6	2010	
المد	Examin	er	4a. Facility Name (if not institution, give street University of Maryland		1		n, or Location			4c. Co	unty of Deat	h
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under LY		24 Hrs.	8. Date of Birt		9. Birt	hplace (State or Foreign
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	with s 23a ust b	Funeral Director	538 N. 6th Street			216	29			USA		
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36	after al", or xami	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗓 No If Yes, Give		1 ☐ Yes 2 🔀	No Specify	<i>'</i> :			_	nite
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Maryland 21215-0036	e filec ntal H ed ot ed ot	To B	17. Father's Name (First, Middle, Last)						e (First, Middle,		name)	
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fureral Service Licensee		2:	2. Name and Ad	dress of Facili	ity PO	Box 160): Gre	enshoi	co. MD
ш	20 2 8 9	10	Melity 10	ly					ein Fur		Home,	PA 21639
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of		death. Do not ent	er the mode of	dying, such as	cardiac o	r respiratory arr	rest,		Approximate Interval Between Onset and Death
ł	nysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		anoxia							Onset and Death
A. Carrier	Examiner		Toolaning in addition	Due to (or as a cons			11.4					
		ner	Sequentially list conditions, b.	Due to for se a con		teal ac	TWING	-			3	
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.									
	executed ian and urial-transi	E	resulting in death) Last	Due to (or as a con-	sequence of):							
9	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ledical	d.									
8	ertifica ding p	/Me	IF FEMALE:	. If yes, outcome of pre	egnancy					004	D-t- of do	l
P.O. Box 68	atten	iciar	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic preg				230	. Date of del Month	Day Year
о В	the de	hysi	9 Unknown	9 Unknown								
7. O	that in the street the	by Physician/M	Part II. Other significant conditions contr	ibuting to death but no	t resulting in the	underlying caus	e given in Part	: l.	23e. Did to	,		the cause of death?
ds,	quires en siç ould b	ted	Septicemia						1 🗆 '	Yes 2 X	No 3 🗆 P	robably 4 🗌 Unknown
Ç	law re as be 2 sh	Completed	Chronic trache	eostomy	on	ventila	ter		24a. Was autor	osy	prior to	topsy findings available completion of cause of
2	: The cate I		Disautonomia				_		1 Yes	rmed? 2 XNo	death?	2 □ No
Ita	sician certifi rector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	spital:			Other:					
Division of Vital Records,	y Physer this eral di	e: To	27. Manner of Death	28a. Date of injury	28b. Time o	f 28c.	njury at		me 5 🗀 Resid 28d. Describe h			ity)
00	ath. rr; Afte	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	r) injury		work? I ☐ Yes 2 ☐	□ No				
NSI NSI	r Atte ter de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A		eet, factory, off	ice		28f. Location (S City or Tow		ımber or Ru	ral Route Number,
בֿ	oital o							1				
	Hosp 24 ho Fune eted f	Medical		On the basis of examin	ation and/or inves	stigation, in my o	pinion, death c	occurred at	the time, date a	ind place, and	d due to the	cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Σ	only one) 3 ☐ Certifying Nurse F 29b, Signature and title of certifier	ractioner. To the pest (or my knowledge,		ense number	o and pido	o, and due to th	29d. Date si		
)-T.B	e M	D	18	942			July	6,2	010
			30. Name and address of person who com				*				-1	
			Toni Biskup 2	2 S. Gree	ne st	Balk	nove,	9 m	2120	10		
	Stat Registra		31. Date filed (Montally, 979 2010	3 Hegistrar's Si	gnatu	and I						

DHMH 17 Rev 7/2009

Tun

Physician/ Medical **Examiner** Funeral **Director** 28a-f show within 72 hours after death with the Maryland the Medical Examiner must be notified at 0 items 23a "natural", or Baltimore, Maryland 21215-0036 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "r permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra

Dennis Sterling Haws

Physician/ Medical Examiner

P.O. Box 68760

Division of Vital Records,

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 4 Donation 5 Other (Specify) 6/29/2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Anylethmia resulting in death) Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be as IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? Pregnant at time of death 5 Other (specify) the 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24a. Was an has autopsy performed? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 KER Outpatient 3 IDOA this completed filled in by the funeral After t Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\superstyle{1}\) Yes 1 🖸 Natural 5 Pending iniury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 🗌 No Accident Investigation 6 🗆 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier (Check only one) 29c. License number 626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOINSBOND Re AD GITACAU (An) LAPPAN! 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8 Date of Birth g. Birthplace (State or Foreign 2/14/1945 Months Days M M 2 I F Hours 218-40-3652 Mary land 65 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Williamsport 1 Yes 2 X No Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 14640 Clear Spring Road 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 1 ☐ Yes 2 🔀 No 3 Widowed 4 X Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Aluminum Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Sterling Webber Bettie Ann Haws 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Troy Haws Sr. 14640 Clear Spring Rd. Williamsport MD Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Hagerstown MD. John T Williams Funeral Home, Brunswick MD. 21716 Approximate Interval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 010

Registrar

JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 22244 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruth H. Hubbell 2010 June Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Nursing and Rehab Walkersville <u>Frederick</u> Social Security Numbe Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 XF Months Min. (Month, Day, Year av 30, 1 Hours Director 068-16-8111 88 May Washington Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√Z Yes 2 ☐ No Frederick Walkersville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21793 56 W. Frederick Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ۵ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Specify Completed 3 X Widowed 4 Divorced white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator garden center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George W. Howell Marion Lock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy H. Whitney/ daughter 3611 Pt. of Rocks Rd., Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2X Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) Smithsburg Crematory June 29,2010 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Keeney & Basford Funeral Home Jarquelin 1/2 MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician disease or condition Inecemani Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or i that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed Pemen tia completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural 24 hours after death. Funeral Director: A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only on 29b. Signat d title of certifier 29d. Date signed (Month, Day, Year) 51643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiren Shah 2170 63

State

Registrar

31. Date filed (Month, Day, Year)

30

32. Registrar's Signate

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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		For State Registrar			State of Maryland / Department of Health and Mental Hygiene O Certificate of Death							IU	22245					
Physicia	ın/	1. Decedent's Name		, Last)								2. Date of Do	eath	Day	Year	3. Time of Death		
Medic Examin	cal	LAW 4a. Facility Name (if	RENCE not institution,	, give stre	RAY eet and numb		NSON	4b	o. City, Town	n, or Lo	ocation of Death	107	4	c. County		10:55 AM		
<i>!</i> 		PENINSULF 5. Social Security No		AAL 6. Sex	Medica	Age (In yrs.	last hirthd	au) If	Under 1 Ye	SAL	//sb4/KU/ If Under 24 Hrs.	O Data of Di	in the	1	(ICOM			
Funeral Director		577-40-0457 Usual Residence of Decedent			M 2 □ F	. Age (iii yis.		Mo				JULY 2	8. Date of Birth (Month, Day, Year) JULY 22, 1930 W			Birthplace (State or Foreign Country) ASHINGTON, DC		
th with the Maryland ms 23a or 28a-f show must be notified at	tor	10a. State		10c. C	ity, Town o	r Locatio	on						10d. Inside City Limits					
ne Mar or 28a- notifie	Funeral Director	DELAWARE 10e. Street and Nun	SUSS	SEX			SELBYVILLE 10f. Zip Code						10g (Vhat Cou	1 🗆 Yes 2 🗓 No			
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nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced 12. Was Decedent Armed Forces; 1 Yes, Give				es? 2 ፟X No	.S.	If Yes	Decedent of s, specify C	Cuban, I	oanic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	-	14. Race	e - Americ k, White,	ean Indian, etc.		
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Depar Impo any ir		ha	elest	NA	forts	29/	2				JNERAL H	-		VILLE	E, DE	. 19975		
Physician/ Medical		23a. Part 1. Enter ti shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List o Final	complicationly one of	ations that calcause on each	used the dea	Ap/	hr.			such as cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death		
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To the Hospital or Attending Physician; The law requires that the death certificate bewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	months?	1 🔲 Live Bi	rth 2 ☐ Fe int at time of	of pregnancy 2						23d. Date of delivery Month Day			ery Day Year			
requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 To																
Physician: The law req this certificate has bee ral director, page 2 shou	Completed by											24a. Was auto perf 1 \(\sum \) Yes	opsy ormed?	- 5		psy findings available mpletion of cause of 2 \square\text{No}		
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Attending Physer death. ector: After thise by the funeral dir	cate: To		1 Yes 2 No Hospital 1 Inpat 27. Manner of Death 1 Natural 5 Pending (Month, Da						njury 28b. Time of 28c. Injury at work?					ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
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To the Hospital within 24 hours a To the Funeral C completed filled	Medical	(Check 2		xaminer	On the basis	of examinati	on and/or in	vestigati	ion, in my or	pinion.	ate and place, a death occurred a me, date and pla	t the time, date	and place	e, and due	to the ca	use(s) and manner stated.		
To with		29b. Signature and t	litle of certifier		>				29c. Lice	ense nu 421	umber 10 7		29d. D	ate signed	(Month,	Day, Year) 2010		
711		30. Name and addre	ess of person v	who com	pleted cause	of death (Ite	m 23a) (Typ	e, Print)	AKES!	· ✓	7.	SAL 151	hueu	1 - 1	20			
Stat Registra	te ar	30. Name and address 1. Date filed (Month	JUL O	2 20	10 32. Re	istrar's Sign	ature A.	pa	w									

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien 20 10

22246 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .Month 23:05 M **Physician** Huana 28 Neinvan June 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1 M 2 □ F **Funeral** Months Days 01/16/1958 China 52 578-31-5052 **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location ms 23a or 28a-f show must be notified at 1 XYes 2 □ No Director Fairmont Heights MD Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code China 20743 1111 60th Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married ö 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: <u>م</u> 3 Widowed 4 Divorced Asian 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Chef Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Hui Qing Li Da Zhang Huang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1111 60th Avenue, Fairmont Heights, MD 20743 Hui Juan Luo - wife Health a Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of demelery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial) 2 Cremation 3 Removal from 7/5/10 Rockville, MD rklawn Mem Park ion 5 Other (Specify) 4 🗌 Do 22. Name and Address of Facility Snowden Funeral Home of Funeral Service Licer 246 N. Washington St, Rockville, MD 20850 ations that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disea se, or comp shock, or heart failur cause on each line. Immediate Cause (Final **Physician** epsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 1 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 2 - No 2 No 1 Yes 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 No 3 DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury or Attending 5 Pending 1 🗌 Yes 2 No investigation death. eral Director: Al filled in by the fu 2 Accident Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29 a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 2010 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FIEN 600 600 North Wolfe St. Baltimore, MD, 21287 3%. Registrar's Signature 31. Date filed (Month, Day, Year) State 01 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] 22247 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Year 1322 Edward June 2010 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Kent hester River Chest If Under 1 Year tou Hospita Center If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 XM 2 □ F Director 73 1 - 12 - 1937WA 526-50-2543 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10a, State 10b. County iral", or items 23a or 28a-f show 1 X Yes 2 □ No Director CA Stanislaus Salida 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4200 Brennen Ct. 95368 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Completed by 3 Widowed 4 X Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Electrical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Dittman Hadden Kirby Grace_Hancock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucinda Cook/daughter 3800 Viader Dr. Modesto, CA 95356 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 Department of I Important: If ite any injury or of 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 6-24-2010 Stevensville, MD 22. Name and Address of Eacility
Fellows, Helfenbein & Newnam Funeral Home 21. Signature of Funeral Service License Romas 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complictions that cause I the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 1050/005 /Medical Due to (or as a consequence of): Examiner muca will Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No detached 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? yes 2 7 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 195 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division of Vital Records,

filled in by

Cc

State Registrar

29c. License number

1 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bown St Cheste form MD 21620 NSO 100

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Registrar's Signatur

			State of Mar		artment of H		, ,	20	110	22248		
			Registrar 1. Decedent's Name (First, Middle, Last)	007	uncate of D	Catri	2. Date of Dea	rieg. Not-				
	Physicia		George C. Kontos				Month 06					
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death			nty of Death			
_			PENINSULA REGIONAL MEDICAL	centr	SAL	isbury			HICANICO			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (ii 214-40-2187	n yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov • 21	Year)	9. Birth Cour	nplace (State or Foreign ntry) Greece		
d. 2			Usual Residence of Decedent	01			NOV . 21,	1920		Greece		
	f sho	tor		0c. City, Town or Lo						10d. Inside City Limits		
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	of the string of	ral	10e. Street and Number 9912 Riverton Road		10f. Zip Code 21837		10g. Citizen o U . S .		intry?			
	ems arm	Funeral Director	11. Marital Status 12. Was Decedent Eve		Vas Decedent of His				ace - Ameri	ican Indian,		
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<u> </u>	und be d Men marke martic	-	Unknown	1		Unkno						
∑	2 sho Ith and 27 is i traur		19a. Informant's Name/Relationship (Type, Print) step- Mary Frances Werner (Jaugh)		ng Address (Street a		narptown	-	, State, Zip 21861			
<u>6</u>	f Head f Head item other		20a. Method of Disposition	ter) 901 (20b. Place of Dispo	sition (Name of		Date Decowi	20c. Location				
E .	Page nent o ant: If iry or		1 😿 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, cren Gardens O	natory or other place f Faith		, 2010	Baltim	ore,	Maryland		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		. Name and Address	s of Facility	Short F	uneral	Home			
			23a. Part 1. Enter the disease, or complications that caused the shock, or hear failure. List only one eause on each line.	e death. Do not ente		East Gro			lmar,	Approximate		
م.	hysiciali <i>i</i>		shock, or hear failure. List only one eadse on each line. Immediate Cause (Final	n set coal	1. OU I	Jours.			ļ.	Interval Between Onset and Death		
	Medical		Immediate Cause (Final disease or condition resulting in death) a. Levy by Due to (or as a condition or as a conditi	_								
	Examiner	<u>.</u>	Sequentially list conditions, b.		4 Days							
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6876	ng phi as th	Med	IF FEMALE:									
9 X	attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?			Date of deliv Month	very Day Year					
Вох	the a	ysic	1 Yes 2 No 4 Pregnant at til 9 Unknown 9 Unknown	me of death 5 L	Other (specify)			, i	ionar	Day roa		
P.O.	been signed by the should be detached	by Pr	Part II. Other significant conditions contributing to death but	ntribute to t	oute to the cause of death?							
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/isic	rector rector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (6	- At home, farm, stre	eet, factory, office		28f. Location (Si City or Town		ber or Rura	al Route Number,		
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ļ	uithin 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	2	29b. Signature and title of certifier	or or my knowledge, C	29c. License			29d. Date sign				
	-		Meen Cooule	MA		32014		6/40/1	10.			
	285		30. Name and address of person who completed cause of deat May ely May 2 / 8 6	uning	rd S/-	5041	5411	shuv	y M	10 21804		
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	Examin	ier	Wicomico		Salis						mico					
	Funeral Director		5. Social Security Number 0111-24-3413 6. Sex 1 □ M 2 □ F 88				ast birthday) Yrs.	If Under 1 Year Months Days	If Und Hour	Jnder 24 Hrs. 8. Date of Birth burs Min. (Month, Day, 1) Apr 25,		th by, Year) 192	2 g. B	e (State or Foreign		
	and show	ē	Usual Residence of Dec 10a. State 10	10c. Cit	y, Town or Loc	ation						10d.	Inside City Limits			
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	To the come come		29b. Signature and title	of certifier	/	7		29c, Licens	e numbe	er / (¹		29d. Date	esigned (Mon	th, Day	Year)	
	3,		30. Name and address	of person who co	ompleted cause	of death (Item	n 23a) (Type, P	rint)	-51			0/	21/10	/ ^		
	14		Mahesha	Thimmar	avappa	M.D.	910 Eas	ternsho	re D	r Sal	isbury	MD 2	21804			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2010 June 28 Leisner 12:12 PM Betty Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis
If Under 1 Year | If Under 24 Hrs. Anne Arundel Medical Center Anne Arundel 9. Birthplace (State or Foreign Country)
Wash., D.C. 5. Social Security Number 8. Date of Birth (Month, Day, Year 04-11-1937 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 ☐ M 2 🂢 F 73 577-52-3145 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumatic event, I'le Medical Examinatination usites and Director 1 ☐ Yes 2 🕅 No Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 807 Bay View Drive 20751 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. □Yes 211 No Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No δ Specify: 3 X Widowed 4 ☐ Divorced white Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Gordon Carr Hilda Catherine Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George P. Halfpap, son 13534 Pace Court, Woodbridge, VA 22193 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) James' Parish 07-02-2010 Lothian, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home. P.A. 8325 Mt. Harmony Lane, Owings, MD 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed and physician are the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical asn IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy ō Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. I the ☐Yes 2☐No signed by the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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10-05136 James Michael Lacombe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 22252
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	•	Ċe	rtifica	te of Dea	ath		,	Re	eg. No.				
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		3109 Mayberry Avenu		301,	Huntingtown						Calvert	Death			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY								9. Birt Foreigi					
Director	213-90-4010 1 X M 2 F 35 Yrs.									/1974	Cou	intry) MD			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she imjury or other traumatic event, the Medical Examiner must be notified at once	Director	3109 Mayberry	Avenue				2	20639		ļ	U.S.A				
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2 hour	Completed	Elementary/Secondary (0-12)	or 5+)		ring most of w					16b. Kind of Bu	siriess/ir	idustry			
5-0036 led within 72 ho Hygiene. other than "n:	nple		4	,	Po]	lice Of	ffice	er			Prince	rince George's			
5-00 led wit Hygien other		17. Father's Name (First, Middle,								irst, Middle, M	laiden Surname)				
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Be	James Michael	·						namlefi						
imore, MD 21215-00; Pages I and 2 should be filed with ment of Health and Mental Hygiene tant: If item 27 is marked other ti or other traumatic event, the Mes	To	19a. Informant's Name/Relations Julie Oursler		ifo							ber, City or Town				
and 2 ealth a rem 2 traum		20a. Method of Disposition	Lacombe/ w							Date	ngtown,				
Baltimore, MD osmit. Pages I and 2 sho Department of Health and Important: If item 27 is mjury or other traumati		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Memorial Gdns 07/16/2010										Dunkirk, MD			
Itim it. Partiment portant	V	4 Donation 5 Other Specify. 21 Signal-Te of Funeral Service Licensee													
Julie Oursier Lacombe/Wife 3109 Mayberry Avenue, Hunt 20a. Method of Disposition 1 x Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funer 81.25 Southorn Md Pland									[unera]	Home C	alve	ert, P.A.			
Physician		18125 Southern Md Blvd., Owings, MD 23a. Part I. Enter the disease, one implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										rt Z(Approximate Interval		
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	344 1 D	rug In	toxi	cation	(Traz	odone	, Zo	lpidem	Zopiclo	ne)	Between Onset and Death		
LAMINICI		or condition resulting in death)	Due to (or as a co				-		•	•					
	<u></u>	Sequentially list conditions, if eny, leading to immediate	b	nsequence o	ıf)·							_			
	лі П	Cause. Enter Underlying Cause [Cisease or injury that initiated c													
cuted and transit	Examiner	events resulting in death) Last Due to (or as a consequence of):													
	edical	d. ☑ UNPENDED ☐ AMENDED 23a,27,28a-f per me g906 8-16-10 vt													
760, Teate be ext physician the burial -	Medi	IF FEMALE:	23c. If yes, out			I PCI	ше ғ	5700 0	10		23d. Date of	lelivery.			
	ician/N	23b. Was decedent pregnant in th past 12 months?	e 1 Live birth		2	Fetal deat	h 3	Ectopic p	pregnanc	/	Month	Da	ay Year		
Box 68' death certificate at the attending and for use as	10	1 Ves 2 No 9 Unknown													
. 4 . 4 .	Phy	Part II. Other significant conditi	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.												
P.O. rres that to signed by	ě	1 Yes 2 No 3 Pro										Proba	ably 4 V Unknown		
rds, requir	Completed									24a. Was a			opsy findings available		
e law e has l	ם									autops	ned? de	eath?	mpletion of cause of		
tal Rec	ပို	25. Was case referred to medical	1				26 Place	of Death (C	heck only	1 Yes 2	No 1	Yes	2 No		
of Vital Records, g Physician: The law require the continue to the continue of	To Be	examiner? 1 ✓ Yes 2 No	Hospital:	atient 2	ER/Outp	atient 3	DOA	Othor -		sing Home 5 Residence 6 ✔ Other Scene					
Of ng Ph		27. Manner of Death	28a. Date of I (Month, Da	njury v.Year)	28b. Tim	e of Injury	28c. Inju	ry at Work?	28	d. Describe h	ow injury occurre	d			
ion trendi leath. tor: /	aţi	1 Natural 5 Pend 2 X Accident Inves			5:00) am	1	Yes 2 X N	lo	Subject	Ingest	ed l	Drugs		
Division of Vital F Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director.	Certification:	3 Suicide 6 Could	not be 28e. Place of	Injury - At ho	ome, farm	, street, factor	y, office t	ouilding, etc.	28	28f. Location (Street and Number or Rural Route Number, City or Town, State) 3109 Mayberry Ave.					
Dj spital hours a neral I	è	4 Homicide	mined (Specify)	House					1	Hunting	gtown, Md	•			
	edical	(Check only	yslcian: To the best of miner:On the basis of e	my knowledo xamination ar	ge, death nd/or inve	occurred at the stigation, in m	ne time, d ny opinior	ate and place n, death occur	e, and du rred at th	e to the cause e time, date a	(s) and manner and place, and du	as stated e to the	d. cause(s)		
To the within To the comple	₩ Wed	29b. Signature and title of certifie	and manner state	ed.				e number			29d. Date signe				
		Dear & Sie	fluit and				O.C.			ŀ	July 9, 2010		/		
	ŀ	30. Name and address of person	who completed cause of	f death (Item	23a)						-				
		Pamela E. Southall, M				111 Pen	n Stree	t, Baltimo	re, MD	21201					
		31. Date filed (Month, Day, Year)	2010 32. Regis	trar's Signatu	re	Brike	h					-			
Regist	(E)	JUL I	LUIU LEN	who ,	15% 1	warra									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 2ďľo 11:10PM Dolores Louise Latella 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Davs Hours Aug. 22 Year 1938 1 □ M 2 🔽 F Connecticut 71 041-30-5897 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗌 Yes 2 🔀 No Maryland Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21157 USA 3402 Randy Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 🔽 No 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Lakeland Schools 12 Librarian Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Cannizzio Albin Ciesielski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Randy Dr., Westminster, MD 21157 Carmelo Paul Latella/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Carroll Cremation Ind 06/24/2010 Hampstead, Maryland 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Princes Timerality Home and Chapel, P.A. 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ancreatic Comonths Due to (or as a consequence of)

Physician/ Medical Examiner

certificate be Box 68760

P.O.

Records,

Division of Vital

To the Hospital or Attending Physician:

Physician/

Medical

10a. State

Director

Funeral

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Completed

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Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at

death v

within 72 hours after

permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

Maryland 21215-0036

Baltimore,

burial-transit physician s the burial attending p for use as t signed by the a within 24 hours after death.

To the Funeral Director; After this certific: completed filled in by the funeral director,

has

certificate

Examir Physician/Medical ð Completed Be မ

Certificate: ca

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Westminster MD 21158

State Registrar

29b. Signature

NJL 5

Name and address of person who completed cause of death (Item 23a) (Type, Print)

WC 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of	Marylan		artment of F tificate of E	lealth and N Death		giene Reg. No. 2016	22254
	sicia /ledic		1. Decedent's Name (First, Middle, ANNA TEREŞA	Last) LAPLACA					2. Date of Dea Month JUNE		3. Time of Death
-	amin	er	4a. Facility Name (if not institution, g					Location of Death ERICK		4c. County of De FRED	eath ERICK
Fun Dire			5. Social Security Number 174-26-7610 Usual Residence of Decedent	i. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. la 95	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb. 19	9. E 9. 1915 P	Birthplace (State or Foreign Country) ennsylvania
laryland 3a-f show	ified at	ector	10a. State 10b. County	ro11		, Town or Loc	cation				10d. Inside City Limits 1 ☒ Yes 2 ☐ No
with the M	ist be not	Funeral Director	Maryland Car 10e. Street and Number 12 Paradise Ave	H-9200	I FIL.	AIIy	10f. Zip Code 217	71		10g. Citizen of What C	
36 fter death ', or items	aminer mu	اھ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deced	2 🔀 No	11	Vas Decedent of Hi	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show	Medical Ex	Completed	3 X Widowed 4 ☐ Divorced 15. Decedent (Specify only highest	Year or Dat s Education grade completed)	es.	16a. Deced	lent's Usual Occupa		ing	Specify: V	White ss Industry
land 212 be filed within ental Hygiene. ked other tha	vent, the N	Be .	Elementary/Seconday (0-12) 12 17. Father's Name (First, Middle, La.	College (1-4	1 or 5+)		<u>Homemaker</u>	18. Mother's Nam	ne (First, Middle, I	Own Ho	ome
Aarylan should be file and Mental is marked of	natic e	욘	Justin Perazza					Carmella	a Berena	to	
			19a. Informant's Name/Relationship Carol Duffy/ Grant		er	1	-			City or Town, State, I	
Baltimore, M bermit. Page 1 and 2 s Department of Health Important: If item 27			20a. Method of Disposition 1 😾 Burial 2 🗆 Cremation 3 4 🗀 Donation 5 🗀 Other (Sp	Removal from S	20b. P State	lace of Dispo emetery, crem	sition (Name of natory or other place	e) 7/7	Date / 2010	20c. Location - City	
Baltimo permit. Page Department of Important: If	any inju		21. Signature of Frineral Service Lice	Min	M						ryland 21702
Pnysic) Med Exami	lical	3 30	23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one caus € on eac a.		n. Do not ente					Approximate Interval Between Onset and Death
ate be executed		l Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c	Seps r as a consequ	ence off:	illa fion				
certificate be	as the bu	Medical		d							
BOX	ched for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of d	I death 3	Ectopic pregnanc Other (specify)	у		23d. Date of o	delivery Day Year
dS, P.O quires that then the signed by	vuld be deta	ן הַ	Part II. Other significant condition	s contributing to de	ath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	/	to the cause of death? Probably 4 🔲 Unknown
DIVISION OF VITAI RECORDS, lal or Attending Physician: The law requires is after death.	page 2 sho	Completed			10				24a. Was a autops perfor 1 \(\sum \) Yes	sy prior to med?/ death?	autopsy findings available o completion of cause of ? 'es 2 No
VITAI /sician: s certific	lirector,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆	ER/Outpatien	Otho	ace of Death (Checi		ence 6 Other (Spe	aoit l
On or ending Physath. er: After thi	ne funeral (Certificate: 1	27. Mann of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investiga	28a. Date o (Month		28b. Time of injury	28c. Injury work	at		ow injury occurred	schy)
DIVISI	lled in by t		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of building	g, etc. (Specify)		eet, factory, office		City or Town		
the Hosp thin 24 hou the Fune	mpleted fil	Medical	(Check 2 ☐ Medical Example only one) 3 ☐ Certifying N	a mine r: On the basis	of examination	and/or invest	igation, in my opinio leath occurred at the	n, death occurred a time, date and place	t the time, date and be, and due to the	cause(s) and manner a	e cause(s) and manner stated. as stated.
5 × 5	8		29b. Signature and title of pertifier.	MP			29c. License	3653		29d. Date signed (Mor	,2010
7				VOAS	of death (Item	23a) (Type, P	Seventh	Street	Frederik	15 CM	701
Reg	State gistra		31. Date filed (Month, Day Year)	0 20 0 ^{32. Reg}	gistrar's Signati	ure A.	parker			7,MD 21	
DHMH 17 Re		_					\$	_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Mar		artment of He <i>tificate of De</i>			ene _{g. No} 2011	22255
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia Medic		Veronica	Jane		Lewis		June	Day Yea 20/0	
	Examin		4a. Facility Name (if not institution, give str		4. /	4b. City, Town, or Lo		,	4c. County of De	/ 1
ممد			TEMINSULA ROGIONAL 5. Social Security Number 6. Sex		in yrs. last birthday)		1456401 If Under 24 H/s.	8. Date of Birth		Birthplace (State or Foreign
	Funeral Director			MODE	51 Yrs.		Hours Min.	9-22-19	58 Ma	Country)
	D wo		Usual Residence of Decedent 10a, State 10b, County	1	Oc. City, Town or Lo	antian				10d. Inside City Limits
	ırylanı a-f sh iled a	Director								1 🗆 Yes 2 🕱 No
	he Ma or 28a o notii		MD Wicomico 10e. Street and Number		Salisb	10f. Zip Code		10	g. Citizen of What	
	with t	Funeral	1429 Pine Way			21	804		USA	
	leath items ier mi	Fun		2. Was Decedent Eve Armed Forces?		Was Decedent of Hisp	anic Origin? (Spec		14. Race - Ar	merican Indian,
36	after c	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X No	0	1 ☐ Yes 2 🏋 No		noun, ocon,	Black, W	4 .
21215-0036	atura cal Ex	Completed	15. Decedent's Educ	Year or Dates.	16a, Dece	dent's Usual Occupation	on	1.1	6b. Kind of Busine	
215	n 72 h e. nan "n Medi	ldmo	(Specify only highest grade	completed) College (1-4 or 5+)	(Give	kind of work done dur O NOT use retired)	ing most of workir	ng	ODI TANG OF BOOMS	oo maaaay
7	l withi ygiene ner th t, the		10			Caretake	r		Medic	a1
Maryland	e filec ntal H ed ott	To Be	17. Father's Name (First, Middle, Last)			1		(First, Middle, Ma		Carlo Carlo
ž	ould bid Meild Mei	·	Richard 19a. Informant's Name/Relationship (Type		Wilkerson	ng Address (Street and	Martha Mumber of Bura	Route Number C	Kreime	
∑	12 shoalth ar 27 is r trau	13	John Whittington,		4					
Jre,	1 and of Hea fitem		20a. Method of Disposition		20b. Place of Dispo				0c. Location - City	
Ë	Page ment ant: It		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Parsons (7-6-2	2010	Salisbury	, Maryland
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fungral Service Licensee	and Bl.		2. Name and Address	, Б		neral Ho	
	00=60		23a Part Enter the disease or complic	cons that caused the						1and 21804
			23a. Part J. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.), /	er the mode of dying,	L.	respiratory arrest	ι,	Approximate Interval Between Onset and Death
	Ph_sician/ Medical		disease or condition resulting in death)	Due to (or as a c	Olm ONQ	ny	bnosis greate			
S. Market	Examiner			F	Ulmono	ing H	yver te	asion		
	_ =	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of):	1	,,			
	and transi	xan	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a c	consequence off.					
	cate be executed physician and s the burial-transit	dical	resulting in death) Last	200 10 (0) 00 0	311004331100 01,1					
200	icate g phys		a.							
89)	ath certifica attending p	an/N	ZOD. Was decedent pregnant	c. If yes, outcome of 1 \sum Live Birth 2		Ectopic pregnancy			23d. Date of	delivery
Box 687	death he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at ti		Other (specify)			Month	Day Year
P.0.	requires that the de been signed by the should be detached	Completed by Physician/M	Part II. Other significant conditions cont	ributing to death but	not resulting in the u	underlying cause giver	n in Part I.	23e. Did toba	acco use contribute	e to the cause of death?
S, D	res th signe d be c	d by						1 \(\text{Yes}	s 2 □ No 3 □	Probably 4 🕻 Unknown
ord	requ been shoul	lete						24a. Was an		autopsy findings available
Division of Vital Records,	sician: The law of certificate has be irector, page 2 s	omp						autopsy performe 1 Yes 2		to completion of cause of i? Yes 2 No
<u>a</u>	ian: T irtifica stor, p	Be C	25. Was case referred to medical examiner?			26. Place	e of Death (Check		A NOT	100 2 2 110
Ž	hysic this ce	မ	1 ☐ Yes 2 🗓 No		t 2 ER/Outpatie		4 ☐ Nursing Ho		ice 6 Other (Sp	pecify)
lo L	ding Par. After t funera	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Y	(ear) 28b. Time o	work?	it 2 es 2 □ No	28d. Describe how	injury occurred	
Siol	Attendar deatl	rtific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	- At home, farm, str			28f. Location (Stre	eet and Number or	Rural Route Number,
Ξ	al or / s after il Dire		4 Homicide determined	building, etc. (City or Town,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a, Certifier 1 Certifying Physici Check 2 Medical Examine							stated. ne cause(s) and manner stated.
	the I	Me	only one) 3 Certifying Nurse I				ime, date and place	e, and due to the ca	ause(s) and manner	as stated.
	5 14 6 8		29b, Signature and title of certifier Well	Vin		D46		29	d. Date signed (Mo	
	1 Jul		20. Name and address of person who com	and tad Jausa of day	th (Item 23a) (Type. I	Print\			4130116	,
	7		Kurt Webberg 100 6	E. Carroll St.	SAlisbury,	Md. 21801				
	Stat		31. Date filed (Month, Day, Year)	E. Carroll St.	Signature	w				
	Registra	ır	JUL U & LUR	- Legend	· 10. 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 22256 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2:12 P andra Kay ong 2010 Ing Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hapers Jashineton (ounty HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 3, 1954 9. Birthplace State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** Mary Land Hours 1 □ M 2 🂢 F Days Min Director 213-68-6540 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 829 West Franklin St. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status چ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Custom Service Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary E. Knarr Long should be Bruce F. Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 829 West Franklin St. Hagerstown, MD 21740 Sterling W. Frisby-Fiance 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5 Smithsburg Crematory 6-29-2010 Smithsburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, aunta 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ng physician and as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Pregnant at time of death completed filled in by the funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an Jas prior to completion of cause of death? autopsy performed 1 Yes 2 No Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 **N**No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certified 29c. License number 29d, Date signed (Month, Day, Year) MD D 0068976 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington (ounty Trum Beyene 31. Date filed (Month, Day, Year) State Registrar

Battimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			Plea	ase Type												
		For State		State	of Ma	arylan	d / Depa Cer	artmer <i>tificat</i>	ntofF e of F	lealth Death	and N	1ental H		_	10	22257
		Registrar 1. Decedent's Name	e (First, Middle	e, Last)				incut	0012	, cati		2. Date of D				3. Time of Death
Physicia Medic		Francis		eimbach								June	29,	^{Day} 2010	Year	11:00 a M
Examin	er	4a. Facility Name (if Mon tgon		eneral Ho		al		4b. City,	Town, or	Location Oln				4c. County M C		omery
Funeral Director		5. Social Security No. 577-16-		6. Sex 1 X M 2 □	7. Age	(In yrs. la	ast birthday) 88Yrs.	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of B Jan•	irth 10 ^{Yea}	^{r)} 1922		hplace (State or Foreign farry land
how how	r	Usual Residence of 10a. State	Decedent 10b. County			10c. City	y, Town or Lo	cation								10d. Inside City Limits
Marylar 8a-f si tiffied	recto	Maryland		Montgo	mery			ver	Sprin	ng						1 🗌 Yes 2 🕱 No
with the 7 23a or 2 ist be no	Funeral Director	10e. Street and Nun		est Roa	d, Ap	t. 1	03	10f. Zij	p Code	2090	16		10g.	Citizen of W	/hat Co	untry?
Defmit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status 1 □ Never Marr	ied 2 🗆 Mar	Armed	ecedent E I Forces? es 2			Vas Deced f Yes, spe				ecify Yes or No Rican, etc.)	0-	Blac	k, White	
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nd 2 shore ealth and n 27 is re			tte Be	hip (Type, Print) ch Swans	on/Da	ught	19b. Mailir er 7					d Route Numb Silver				
Page 1 ar nent of He int: If iter iry or oth		20a. Method of Disp 1 Burial 2 4 Donation	Cremation	3 ☐ Removal fi Spec <i>ify)</i>	rom State	C	lace of Dispo emetery, cren tropol	natory or o	ther place	e) ator	.T11	oate OYo ¹		Location -	•	Town, State VA
permit. I Departn Importa any inju once.		21. Signature of Fu	neral Service	icensee M	c Nu	1~	1º	ranci	nd Addres	s of Facili	Žins	Funera	al H	lome I	nc.	ng, MD 20901
		23a. Part I. Enter t		complications th		the death			_					ver s	pri	Approximate
Physician/ Medical		Immediate Cause (disease or condition	Final	a		NE	UMO	N	IA					_		Interval Between Oncet, and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	4 🔲 F		2 🗌 Feta	ldeath 3	Ectopic Other (s _i		у			-	23d. Dat Moi		ivery Day Year
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require been si should	leted	- TERO) (10	7)1	V	1770	/ C J:	2Ci ²	1000	24a. Wa				robably 4 Unknown topsy findings available
sician: The law s certificate has k lirector, page 2 s	Completed	16 120										aut per	topsy rformed	? 5	orior to death?	completion of cause of
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ending sath. or: After he fune	Certificate:	1 Natural 2 Accident	5 Pendi	ng (A gation	Nonth, Day		injury	М	work			zod. Describe	e now in	jury occurre	u	
tal or Att rs after de al Directo ed in by t		3 Suicide 4 Homicide	6 ☐ Could determ	nined 28e. Pl	ace of Inju iilding, etc		me, farm, stre	et, factor	y, office			28f. Location City or To			r or Rui	ral Route Number,
e Hospi 124 hou e Funer leted fill	Medical	(Check 2	Medical I	Physician: To the Xaminer: On the Nurse Praction	basis of ex	amination	and/or invest	tigation, in	my opinio	n, death o	ccurred at	the time, date	and pla	ace, and due	to the c	cause(s) and manner stated.
To the Comp	2	29b. Signature and			01	1	^	290	c. License	number			29d. l	Date signed	(Month	n, Day, Year)
1271		30. Name and addre	ess of person	who completed	ause of de	eath (Item	23a) (Type, F	- /1	DO	0 7	16	50	0	0	>0	-2010
		Anuradha A	run, MD	10309	Georgi	a Ave	nue, #20	09, Si	lver	Spring	g, MD	20902				
Stat Registra		31. Date filed (Monti	h, Day, Year) L 012		2. Registra	r's Signat	ure Jan	Wed.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22258 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 06/28/2010 HENRY HARDWICK H. LLOYD 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Min. Months Hours 07/02/1921 Director 577-74-5678 88 Panama Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 531 Randolph Road, 20904 #330A should be filed within 72 hours after death w and Mental Hygiene, is marked other than "natural", or items: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian injury or other traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cabinet Maker Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Viola Haye Danield Byron Agustus Lloyd and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verenicia Robinson - friend 9317 Grazing Terr., Montgomery Village, MD 20886 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from 4 Donation 5 Other (Specify) of Heaven 7/2/10 Silver Spring, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 art 1. Enter the dise cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ metast Medical resulting in death) Examiner equalitizing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of) Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 Do

9 Unknown Pregnant at time of death ed by the 9 Unknown signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one)

Physician: The law requires that the death certificate be Box 68760 P.O. Records, of Vital Hospital or Attending Division

To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 1 examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide work? 1 ☐ Yes injury 5 Pending Investigation 2 🗆 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069829 Tehseen R. Nagvi, 203- Ballu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL Registrar **ORIGINAL**

	Please	e Type or Print in I State of Marylan				-			00050
	1 - State Registrar 1. Decedent's Name (First, Middle, La			ificate of L		2. Date of De	Reg. No.	/ H	22259
cian/ dical niner	Raymond L. 4a. Facility Name (if not institution, giv	Morell ,	Sr.	4b. City, Town, or	r Location of Death	June Month	2 ^{Day}	2010	5:35 P M
ral		Sex 7. Age (In yrs. I	ast birthday)	Harwo If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth	nne Arur 9. Birth Cou	nplace (State or Foreign
or	191–32–6145 Usual Residence of Decedent 10a. State 10b. County		Yrs.			(Month, Di	7, 19	941 Per	nnsylvania 10d. Inside City Limits
Director	FL Lee		Cape (Coral			10a Citiz	zen of What Cou	1 X Yes 2 □ No
Funeral	5793 Cape Harbou	12. Was Decedent Ever in U.S		339 as Decedent of H	ispanic Origin? (Sp		Ţ	JSA 4. Race - Ameri	· · · · · · · · · · · · · · · · · · ·
ted by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		Yes, specify Cuba	an, Mexican, Puerto Specify:	Rican, etc.)	8	Black, White,	, etc. hite
Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)	rade completed) College (1-4 or 5+)	(Give ki life. DC	ent's Usual Occup ind of work done of NOT use retired) rtgage B	duning most of work	king		nd of Business Ir tgage Ba	
To Be (17. Father's Name (First, Middle, Last) Anthony Morell	5+ 	110.	e eguge D	18. Mother's Nam Helen	ne (First, Middle White			<u> </u>
	19a. Informant's Name/Relationship (Raymond Morell,				and Number or Run Drive, I				Code)
once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐ Removal from State	Place of Dispos cemetery, crem-		ce) Tune	Date 29,	20c. Loc	cation - City or T	
ouce.	21. Signature of Funeral Service Lines	and the same of th	— Ba 49	rranco & 5 Ritchi		A. Seve	erna l	Park Fu Park, M	neral Home D 21146
n/ eal	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the deat one cause on each line. a. Due to (or as a consequence)	lute	the mode of dyin			rrest,	,	Approximate Interval Between Onset and Death
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b. Due to (or as a consequ	uence of):						
ш	that initiated events resulting in death) Last	Due to (or as a consequent of d.	uence of):						
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnant Live Birth 2 Feta Feta Pregnant at time of 0 Unknown	al death 3	Ectopic pregnand Other (specify)	су		2	3d. Date of deli Month	ivery Day Year
<u></u>	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	nderlying cause giv	ven in Part I.				the cause of death?
Completed						perf	s an opsy formed? 2 2 No	prior to c death?	opsy findings available completion of cause of
To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatient	Oth	er:	ck only one)		MA:	OCTIVE TO WE
Certificate: 7	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injur work M 1 🗆	v at	28d. Describe			
I -	3 Suicide 6 Could not 4 Homicide determined			et, factory, office			(Street and wn, State)	Number or Rura	al Route Number,
Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	ysician: To the best of my know niner: On the basis of examination rse Bractioner: To the best of m	n and/or investi	gation, in my opinio	on, death occurred a	at the time, date	and place,	and due to the c	ause(s) and manner stated
	29b. Signature and title of certifier	6		29c. Licenso	e number	7	29d. Date	e signed (Month,	, Day, Year)
(50. Name and address of person who	Delvento	305	int) HOSPI	Jol De	we sole	nBy	my My	21061
state strar	31. Date filed (Month, Day Year) 0	2010 32. Registrar's Signa	ture A. A	hare		,		,	. ,

DHMH 17 Rev 7/2009

Certificate of Death

2. Date of Death Month

Dav

Year

2010

Black, White, etc.

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

White

Cecil

21:15

Birthplace (State or Foreign Country)

Pennsylvania

10d. Inside City Limits

DE 19709 Approximate Interval Between Onset and Death

Year

1 ∐Yes 2√∑No

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Physician GRACE T. MOORE June /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Elkton Care & Rehabilitation Elkton If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🙀 F Director 198-03-676 3/17/1919 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventimer must be notified at once. DE Director New Castle Bear 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 110 Walls Way 19701 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes AFANo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Publisher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Cunningham ပ္ Iva May Titus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine Shetzler/Daughter 110 Walls Way, Bear, DE 19701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Philadelphia Memorial Park 6/26/2010 Philadelphia, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee DANIELS & HUTCHISON FUNERAL HOME LLC 23a. Part 1. Enter the disease, ox complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ICIDNEY DISISASE CHRONIC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 □Yes 2 🗆 No Director: A in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number b. n. nonto No065733 06/23/10 MD 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Narayana Pula, MD, 126A East High Street, Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JUN 2 5 2010 Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State State Registrar	Cen	tificate of D			eg. No 2010	22261
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Barbara Je	oon Markle			2. Date of Deat Month	24 2010	3. Time of Death 1152 M
,	Medic Examin		4a. Facility Name (if not institution, give street and n	umber)	4b. City, Town, or			4c. County of Deat	h
تعريد	,		Carroll Hospital (5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Westn	ninster If Under 24 Hrs.	8. Date of Birth	Cari	thplace (State or Foreign
	Funeral Director		538-34-7036 1 □ M 2 🛣	7. Age (in yrs. last birthday)	Months Days	Hours Min.	6/22/1	938	untry) WA
	land show dat	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
	Mary 28a-f	Director	MD Carroll	Taneyt					1 Yes 2 No
	with the 23a or 1st be 1	Funeral [10e. Street and Number 5941 Conover Rd.		10f. Zip Code 217 8	37	1	10g. Citizen of What Co USA	ountry?
20	e filed within 72 hours after death with the Maryland trail Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Married Armed 1 Yes, 6	es 2 🔼 No Give 1	/as Decedent of His Yes, specify Cubar ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: wh	e, etc.
2-0030	2 hours "natura edical E	Completed	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Decede	ent's Usual Occupa ind of work done d	ation uring most of work	áng	16b. Kind of Business	
717	within 7 giene. er than , the Me		Elementary/Seconday (0-12) College	(1-4 or 5+)	NOT use retired)			Foundry	
yland	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) William T. Wren			18. Mother's Nam	ne (First, Middle, N h Newla		
Mary	should be fi and Menta ' is marked raumatic ev		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	g Address (Street a			City or Town, State, Zip	o Code)
e, ĕ	1 and 2 should be of Health and Men item 27 is marke other traumatic		Frederick B. Markle 20a. Method of Disposition			nover l		neytown,	
_	Page 1 anent of hand of hand; If ite		1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)		atory or other place			010 Tanes	· · ·
Dairimo	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licensee	22.	Name and Addres	s of Facility			17340 ittlestown
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on	at caused the death. Do not enter			_		Approximate Interval Between
- 4	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	ALDIAC AL	RHYTH	MIA			Onset and Death
	Examiner	Ļ		co (or as a sorrisoquerios siji					
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	to or as a consequence of:					
	icate be executed j physician and is the burial-transi	al Exa	that initiated events c	to (or as a consequence of):					
00/	icate be physic s the b	edical I	d						
00 X 00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	outcome of pregnancy ve Birth 2 Fetal death 3 regnant at time of death 5	Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
o o	t the de by the tached	Physi	9 Unknown g U	nknown		in Dont	1		() ()
, T.	ires tha	by	Part II. Other significant conditions contributing to	o death but not resulting in the ur	nderlying cause giv	en in Part i.		oacco use contribute to	robably 4 Unknown
vital Records,	aw requas beer	Completed					24a. Was a	prior to	topsy findings available completion of cause of
ב	n: The lificate h	_	25. Was case referred to medical		00.5	(5, 11, (0)	1 Yes		s 2 🗆 No
V	ysiciar is certii directo	To Be	examino? Hospital:	☐ Inpatient 2 ☐ ER/Outpatien	Othe	ace of Death (Checer: $4 \square$ Nursing H		ence 6 🗆 Other (Spec	cify)
5	ding Ph h. After th funeral		1 Natural 5 ☐ Pending (M	ate of injury 28b. Time of injury injury	28c. Injury work M 1 □		28d. Describe ho	ow injury occurred	
DIVISION OF	or Attender frer deat irector; n by the	Certificate:		ace of Injury - At home, farm, stre ilding, etc. (Specify)		100 2 110	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
5	ospital of hours a nuneral Ded filled i	Medical (29a. Certifier 1 Certifying Physician: To the	e best of my knowledge, death o basis of examination and/or investi	ccured at the time,	date and place, a	nd due to the cau	se(s) and manner as sta	ated.
	the Hithin 24 the Fi	Me		er: To the best of my knowledge, d		time, date and pla	ce, and due to the		stated.
	F 3 F ŏ								
1	2910		30. Name and address of person who completed c	ause of death (Item 23a) (Type, P	rint)	MORIA	LAVE.	WESTMINS	5,2010 21157 TER.MD
***	Stat	e_		Registrar's Signature		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Registra		11111 2 8 21111 17 8	LAMBOUR C. LINES	Jean De la Company				

Physician /Medical Examiner

Funeral

1 □ M 2 🖾 F Vrs 73 233-56-3133 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at Director Frederick Frederick MD 10f. Zip Code 10e. Street and Number 21702 7021 Rock Creek Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 □ No þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 17. Father's Name (First, Middle, Last) Be Helen Lugar Roy W. Kelican ပ 19a. Informant's Name/Relationship (Type. Frint) Tyler Neff/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resthaven Mem. Grdns. 6/29/10 4☐Donation 5☐Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses L Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the control of the cont Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Izhermers resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ COPI Completed 24a. Was an 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 ☐ Could not be determined 4 Homicide Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature a of person who completed cause of death (Item 23a) (Type, Print) CRNP Raton 4202 32. Registrar's Signature 31. Date filed (Month. Day. Year) State

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11:35 AM 26 2010 June CARLEEN KELICAN MORT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Rock Creek Drive Frederick 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth Days 3/22/1937 10d. Inside City Limits 1 ☐Yes 2☐No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Maryland Counseling 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Boileau Court, Middletown, Maryland 20c. Location - City or Town, State Frederick, Maryland Robert E. Dailey & Son Funeral Homes, P.A. 1201 N. Market St., Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Resp. dyfx 3 to metabolic imbalance as it Due to (or as a disequence of) related to Alzheimers 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3-Nucse Proced: the open and manner stated. 29d. Date signed (Month, Day, Year) green Valley Rd Monrovia, MD

Registrar

Charin.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ June 22 8:30 p. M Doris H. McCarthy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Sunrise Senior Living Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthdav. **Funeral** 1 □ M 2 🕱 F Hours Aug 14, Year 23 86 New York **Director** 086-18-0675 Usual Residence of Decedent 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene.

Them 27 is marked other than "natural", or items 23a or 28a-f shoor filem 27 is marked other than "natural", or items 23a or 28a-f shoot filem to other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Boonsboro <u>Maryland</u> Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21713 United States 7620 Mapleville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify. Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 4 College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Grace Warner John Hofmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7620 Maplewood Road, Boonsboro, Maryland 21713 James McCarthy - son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington National 8/17/2010 Arlington, Virginia 21. Signature Inneral Service Licens 22. Name and Address of Facility Stauffer Funeral Home Pike, Frederick, Maryland Opossumtown 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Lux discuse Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a P.O. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed Yes 2 R No 1 Ves within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🖲 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🙅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title

Registrar

State

14E11

32. Registrar's Signature

	•	For State Registrar	Sta	ate o	of Marylar		artmen <i>tificat</i>			and Me	ental Hy	/gien	010	22264	ł
		1. Decedent's Name (First, Middle	e, Last)								2. Date of D	eath Da	ıy Yea	3. Time of Dear	th
Physicia /Medic		Katherine El	izabet	:h	Miller						June	28	•		М
Examine	-	4a. Facility Name (If not institution	n, give street	and no	umber)		4b. City,	Town, or	Location	of Death		40	. County of De	ath	
		Broadmore Ass	isted	Liv	/ing		Н	ager	stowr	1			Was	hington	
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under Months		If Under Hours		8. Date of B (Month, D	irth		Birthplace (State or For Country)	eign
Director		218-24-1569	1 □ M 3	2 ∏ F		82 Yrs.	MOTHE	Days	Hours		June 1			Maryland	
9		Usual Residence of Decedent												1444 14 60 14	
trylar show	_	10a. State 10b. County			10c. Cr	ty, Town or Lo	cation							10d. Inside City Lin	
99-1 e	용	Maryland Was	hingto	on_		Hag	gerst					1		1 □ Yes 2√	
or 2	Director	10e. Street and Number					10f. Zip					10g. Ci	itizen of What	Country?	
72 hours after death with the Marylan 72 hours after death with the Marylan "neturel", or Items 23a or 28e-f ehow citical Examiner is ust be notified at	<u>a</u>	1175 Professi							1740			L.,	US		
r deg	Funeral	11. Marital Status	A	rmed F	cedent Ever in U orces?	J.S. 13.	Was Deced f Yes, spec	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spec 1, Puerto F	cify Yes or N Rican, etc.)	lo-	14. Race - Ar Black, W	merican Indian, hite, etc.	
S atte	핏	1 Never Married 2 Mar	l If	Yes, G			1 🗆 Yes	2 \ No	Specify:				Specify:		
urei;	d by	3∰Widowed 4 □ Divorced		ear or l	Dates:	1 10: 5						105	Zind of Busines	White	
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be filed within 72 hours after death with the Maryland tal Hygiene. I hours after death with the Maryland tal Hygiene. I do ther then "netural", or Items 23s or 28s-1 show event. I'm Madical Examiner is ust be notified at	e Co	17. Father's Name (First, Middle,	Last)			1		1	18. Mothe	er's Name	(First, Middi				
d be initial sed o	m	Harry Russell	•	n					Anni		lorenc				
should nd Men i marke umatic	2	19a. Informant's Name/Relations				19b. Mailir	na Address	(Street a					or Town, State	a. Zip Code)	
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pornit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hygiens. Informer, it items 7 is marked other then "neturel", or liems 23a or 28e-1 ehov eny injury or other treumstic event. The Medical Examiner must be notified at once.		Carolyn Hardt- 20a. Method of Disposition	Daugnt	er	20b. I	Place of Dispo	sition (Nar	ne of	- 1	alli	ng_Wat ate	20c. L	ocation - City	Virginia or Town, State	
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rtme	-	'4 □ Donation 5 □ Other (S		A	Ced								erstow	Maryland	1
permit. Departi		1 2/19)_/			1,555					e, P.A			- MD 0170	
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		shock, or heart failure. List	only one ca	use on	each line.		1	o or ayırı						Interval Between Onset and Death	
Physician /Medical		disease or condition resulting in death)	a		01000		141	2~	1`	1)154	251				
Examiner		,		Due to	o (or as a consec			(, ,	. 1	4 1/A/M	La Cal	hy			
	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to	o (or as a consec	quence of):	<u> </u>	C CC.	4 6 1	- (11.				
ted	Examiner	Cause (Disease or injury	<		ما م	tic		.00	11	tur	to Can				
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that		Part II. Other significant conditi	ons contribu	ting to	death but not re	sulting in the u	nderlying d	ause give	en in Part I		23e. Dio	d tobacco	use contribute	e to the cause of death	1?
uires uires ild be	d by										1 [Yes 2	2 □ No 3 □	Probably 4 Hakn	own
w req	Completed										24a. Wa	is an	24b. Were	autopsy findings avail	lable
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sicien: The law certilicate has b	e C	25. Was case referred to medica	ul l						OC Dies	a of Donth	1 Yes		0 1 1 1	res 2□No	
sicie cert irect	o B	examiner?	Hospit	tal: , _	Inpatient 2	ER/Outpatier	nt 3 🗆 D0	Othe			<i>(Check onl)</i> ne 5 ☐ Re		6 Other (S	Pageity ASSIST	ed
Phys	-	27. Manner of Death	28	a. Date	e of Injury	28b. Time o		28c. Injury	/ at				ury occurred	アング	4
th.: Atte	tioi	Natural 5 ☐ Pendii 2 ☐ Accident investi	ng igation	(Mo	onth, Day Year)	Injury	М	Work	<7 Yes 2 □	No				0)
Atter dea octor	fica	3 ☐ Suicide 6 ☐ Could			ce of Injury - At h		eet, factor	y, office		2	28f. Location	(Street a	and Number of	Rural Route Number,	
atte din t	Certification:	4 ☐ Homicide		buil	ding, etc. (Speci	ity)					City or I	own, Sta	te)		
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifyi	ng Physiciei	n: To th	ne best of my kn	owledge, deat	h occurred	at the tim	ne, date ar	nd place, a	and due to th	e cause(s) and manner	as stated.	
e Ho	edical	(Check only 2 Medical one)			basis of examin inner stated.	ation and/or in	vestigation	n, in my op	pinion, dea	ath occurre	ed at the time	e, date ar	nd place, and	due to the cause(s)	
To the withing To the comp	Me	29b. Signature and title of certifie	or ~~	سلم	^				e number	/		29d. D	ate signed (M	onth, Day, Year)	
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		30. Name and address of person				m 23a) (Type,	Print)	11.	26	ĉ	Pal	e	+		
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Sta	te	31. Date filed (Month, Day, Year, JUN 3	0 2040	32.	Pegistrar's Sign	nature	host	1		0					
Registra	ar	JUN 3	W ZUIU	1	Brew	P. 14	COCI								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22265 Reg. N 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1120 PM Charlotte Elizabeth Michael Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington county 5. Social Security Number if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) PC. I, 1927 Days 1 - M 2 X F 220-20-2139 82 Mary Land Dec. Director 3a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13118 Woodburn Dr. must 21742 U.S.A. items "natural", or item ledical Examiner n Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🎇 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. Specify: White De filed whu..
Mental Hygiene.

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"It, the Medical Ey 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker it. Page 1 and 2 should be filed with them of Health and Mental Hygien rant: If item 27 is marked other 1 njury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mark Joseph Kirby Maude Elizabeth Kraft Kirby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas C. Michael-son 13118 Woodburn Dr. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 7-7-2010 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Cardiomy palm Onset and Death Physician schem. Medical resulting in death) Due to (or as a consequence of) Examiner ibr. Malior a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) 9 Unknown g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? io the runeral birector. After this certificate has been signed completed filled in by the funeral director, page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending death. ☐ Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060 396 06

Registrar

21740

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V224EU

egistrar's Signature

MV

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31. Date filed (Month, Day, Year) **2010**

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by		ied 2 🔛 Married	Armed Forces? 1 Very Yes 2 If Yes, Give			If Yes, spec	ify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White Specify:	e, etc.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 22267 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month SUNE 2010 0257 M James Nicholson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** Year (Month, Day, Year) 3-29-1955 1 👿 M 2 🗆 F Days Months Hours 214-60-9897 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Sussex Laure1 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 23a 6186 Ralphs Road 19956 items ? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. 2 1 Never Married 2 X Married "natural", or should be filed within 72 hours after and Mental Hygiene. ₩ Yes 2 No 1974-1 ☐ Yes 2 🙀 No 3 Divorced 4 Divorced White Completed 1975 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nicholson, Jr. Bettv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Betty Breasure - Mother 6186 Ralphs Road, Laurel, Delaware 19956 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o Page 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MDVeterans Cemetery 7-2-2010 Hurlock, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home Salisbury, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 No 1 Yes To the Hospital or Attending Physician: 7 within 24 hours after death.

To the Funeral Director: After this certific: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 4 Homicide injury 5 Pending Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number

State Registrar

Baltimore, Maryland 21215-0036

Records,

Division of Vital

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

h (Item 23a) (Type, Print) lock milter of St C/V Delma welter the Suttilis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22268 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Mirta Iris Nanavichit 11:57 A^M June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manorcare Silver Spring Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 3, **Funeral** 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 🗆 M 2 🛣 F Hours **Director** 60 220-56-4134 Feb. Puerto Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at Director or 28a-1 1 Yes 2 X No MD Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 3227 Hollyhock Drive 20866 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 🛛 Yes 2 🗆 No Specify: Puerto Rican "natural", Completed 3 Widowed 4 X Divorced Year or Dates White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dental Hygienist Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental F Jose Alvarado Melendez Maria Nicolasa Rosario 19a. Informant's Name/Relationship (Type, Print) Son-in-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Chatchares Chitvaranund 3227 Hollyhock Dr., Burtonsville, MD 20866 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 06/29/2010 | Silver Spring, MD Sign to re f Furreral Survice Libense 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Eleter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAY Immediate Cause (Final Priysician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** FAILURE TO THRIVE Months Sequentially list conditions, Examine If any leading to in modiate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Cause (Disease or iinjury that initiated events DEMENTIA Years Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🖾 No for Pregnant at time of death the 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe or Attending Physician; The law requires OSTEOPOROSIS Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform certificate Yes 2 X No 1 Yes 2 No apleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 XX Nursing Home 5 - Residence 6 - Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and addr

31. Date filed (Month, Day

Raman Rekha Tuli,

10810 Darnestown Road, Gaithersburg, MD 20878

ss of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

MD,

June 28, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 22269 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ James Franklin Ohler 2010 2:53 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Oct 11, 1943 Social Security Number 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** 1 **X** M 2 □ F Months Maryland 220-40-9288 66 Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Carroll Taneytown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral 23a 21787 USA 11308 Keysville Road or items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 Married è Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 'natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Commodity permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important, if item 27 is marked other than any injury or other traumatic more. Elementary/Seconday (0-12) College (1-4 or 5+) Carrier Truck Driver 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy R. Ohler Iva M. Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Ohler, brother 11308 Keysville Road, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of Settle) crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/24/2010 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 inter 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of: Examiner PINUONUO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Nonpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28b. Time of 28c. Injury at Watural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WIL 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21740 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22270 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month / 29 / 2010 3:40 A M Bonita A. Porter Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 1714 The Strand Carrol1 Westminster Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**X Months Days Hours Min. (Month, Day, Year) 8/4/1956 Country) Director 216-68-7629 53 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1714 The Strand 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give "natural", Specify: 3 Widowed 4 Divorced Completed White Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Page 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other tha College (1-4 or 5+) Doctor's Office 12 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Goldie Henard James Lanning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 The Strand, Westminster, MD 21157 Dennis Porter/Husband 20c. Location - City or Town, State MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date permit. Page 1 Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 2, 2010 Marriottsville, Crestlawn Mem. Gardens 21. Signat in of Funeral Service Licenses Burrier Wiefer Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 23a. Part I. Enter the disease, or complication shock, or heart failure. List only one call mmediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. nterval Between Breust Cancez Physician METACTALL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death Other (specify) Yes 2 No ed by the a detached f 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 44 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) WJL Mes 38500 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JUN 29

Nicholas W. Koutrelakos, M.D., 10710 Charter Dr., Suite G020, Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - State Registra Certificate of Death 2. Date of Deatl cedent's Name (First, Middle, Last) Physician/ Month 8:32 PM hel Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Deat **Examiner** Music 8. Date of Birth (Month, Day, Sept. 2 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F 220-12-0170 86 T923 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I freem 27 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director Easton Talbot MD 1X☐ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21601 501 Dutchman's Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 1 Never Married 2 Married 1 Yes : 2 DXNo Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify. Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Own Home Homemaker Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Cora Brodes Roy M. Legates, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Larry Phillips/Son 1460 East 450 South, LaGrange, IN 46761 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Junior Order Cemetery 07/07/10 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, PA. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician/ intraceresial disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 a autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မ Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director, / 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

3 🗆

Name and address of person

JUN 88

31. Date filed (Month, Day, Year)

only one)

29b. Signature and title of ce

DHMH 17 Rev 7/2009

pleted cause of death (Item 23a) (Type, Print)

110

MI

Registrar's Signatu

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

(xmars

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 602M Frances Irene Park Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Talboi Memorial Hospita 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 👿 F 83 Director Canada 213-56-4170 ent Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 Colonial Drive 21629 United States of America permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Caucasian 3 XWidowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Winnifred Mae West Dempster Lorne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 343 CandleRidgeCourt, Arnold, MD 21012 Patricial. Miller /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State CapitolCrematory 7/2/2010 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTROINTESTINAL COWER Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** ANEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant signed by the a

or the Hospital or Attending Physician: The law requires thin 24 hours after death.

The Funeral Director: After this certificate has been sign mipleted filled in by the funeral director, page 2 should be

Hanes

Completed by Be မှ Certificate:

Medical

29b. Signature and title of certifie

<u>John Botsis, M.D</u> 31. Date filed (Month, Day, Year)

JUL 0 2 2010

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of g ☐ Unknown	death 5 Other			Month Day Year
Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Part I.		o use contribute to the cause of death? 2 Mo 3 Probably 4 Unknown
				24a. Was an autopsy performed?	
25. Was case referred to medical			26. Place of Death (Che	eck only one)	
examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:	☐ ER/Outpatient 3 ☐	DOA Other: 4 \(\subseteq \text{Nursing} \)	Home 5 Residence	6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 Suicide 6 Could not 4 Homicide determine	1 28e Place of Initin/ - At h		ory, office	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
(Check 2 Medical Exa	nysician: To the best of my know miner: On the basis of examination urse Practioner: To the best of m	on and/or investigation,	in my opinion, death occurred	at the time, date and pla-	ce, and due to the cause(s) and manner stated

29c. License number 70059487

219 South Washington Street, Easton, Maryland

29d. Date signed (Month, Day, Year)

7-1-2010

Registrar DHMH 17 Rev 7/2009

State

To the Hosp within 24 hou To the Funer completed fil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar 22273 Certificate of Death Rea. No Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2010 Physician/ June June Wilma Ryan Parker 29 3:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gaithersburg Montgomery Wilson Health Care Center Social Security Number , Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ X= Months Davs Hours Min. Maryland 04/29/1919 220-07-6294 91 Yrs Director Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 301 Russell Avenue #401 United States be filed within 72 hours after death tental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give White "natural", Specify: Completed 3 XWidowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Billing Clerk Insurance Company 1 Be 2 should be h. ~ ~ Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o 2 Myrtha Miller Alvey Ryan permit. Page 1 and 2 should Department of Health and M Important; If item 27 is mar any injury or other traumati once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Parker Chardavoine(Daughter) 540 Allegheny Avenue, Towson, Maryland 21204 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 30 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate or heart failure. List only one cause Interval Between Onset and Death Years Immediate Cause (Final Physician Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Year Day Pregnant at time of death Unknown 9 Unknown t signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2**X** No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on title of 일 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) June 30, 2010 D19294 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melnick M.D. 911 Russell Avenue Gaithersburg, Maryland 20879 ' R, Month, Day, Year)
JUL 0 1 2010 Registrar's Signature State Registrar

Estelle Powell

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		-	For State Registrar		State	e ot ivia	aryıand		artment of tificate of			ientai Hy	/giene Reg. No	/ 11	10	22274
	Physicia		1. Decedent's Name EDITH ES'		-							2. Date of D Month		د الإ	Year -010	3. Time of Death
	Medic Examin		4a. Facility Name (if	not institution	, give street and				4b. City, Town,		of Death		4c	. County o	of Death	
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	è	1 Never Marr 3 Widowed		. If Yes	d Forces? Yes 2 X , Give or Dates.	No	- 1	f Yes, specify Cu			Rican, etc.)		Black Specify:	k, White, Bla	
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Baltimore,	bage 1 arent of Hent o		20a. Method of Disp 1 □XBaria 2 4 □ Domation	☐ Cremation	3 Removal	from State			sition (Name of natory or other p Cemete		7/7/) 10		ocation - manto	•	own, State
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. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be of 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicial theorem of the funeral director, page 2 should be detached for use as the but the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 g ☐ Unknown	months?	1 4 🗆	Live Birth	of pregnand 2 ☐ Fetal of t time of de	death 3 🛚	Ectopic pregna Other (specify)	ancy				23d. Dat Mor	e of deliv	ery Day Year
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ono	anding rath. rr. Afte	licat	1 Natural 2 Accident		igation	Month, Daj	v, Year)	injury		ork? □ Yes 2	□ No					
Division of Vital Records,	l or Atte after de Directo I in by th	Certif	3 ☐ Suicide 4 ☐ Homicide	6 L. Could detern	28e. F	Place of Injudicity		ne, farm, str	eet, factory, offic	е			(Street ar own, State		r or Rura	Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical Certificate:	(Check 2	Medical	g Physician: To the Examiner: On the	e basis of e	xamination a	and/or inves	tigation, in my op	inion, death	occurred a	t the time, date	and place	e, and due	to the ca	use(s) and manner stated
	To the vithin to the comple	Ž	only one) 3 29b. Signature and		g Nurse Practio	ner: To the	best of my l	knowledge,		nse number		ce, and due to				Day, Year)
	7		Mine	1 6d	"" /				DI	4116	2		2	. 1 =	2	6 2010
	6		30. Name and addr	ess of person	who completed		eath (Item 2	23a) (Type, F	Print)	vive	G	crea	nte	w	N	020874
	Sta Registr		31. Date filed (Mont	th, Day, Year) 0 1 2	010	32. Registra	ar's Signatu	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:27 P M Despina Polyxene Papaspyrou June 29 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdav) Funeral Months Days Hours Min. 1 □ M 2 🖵 F Director 215-98-1651 43 8/24/1966 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Medical Eventual Province must be seen any injury or other traumatic event, If a Medical Eventual Province must be seen any injury or other traumatic event, If a Medical Eventual Province must be seen and any injury or other traumatic event, If a Medical Eventual Province must be seen and any injury or other traumatic event, If a Medical Eventual Province must be seen and any injury or other traumatic event, If a Medical Eventual Province must be seen and any injury or other traumatic event, If a Medical Eventual Eventual Province must be seen and any injury or other traumatic event, If a Medical Eventua 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Anne Arundel Riva 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3067 Tudor Hall Rd. 21140 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify δ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) County Civil Engineer years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael John Mostakis Irene Theonas ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Papaspyrou/ Husband 3067 Tudor Hall Rd., Riva, Maryland 21140 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Demetrios Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/2/10 Annapolis, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day Pregnant et time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 DNC 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pe cause of death (Item 23a) (Type, Print) 150 31. Date filed (Month, D Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 22276 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HOLDSKO HENES Month DEDA 2318 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arundel Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
July 14,1923 9. Birthplace (State or Foreign Country) West Virginia Funeral 1 M 2 F 235-22-5688 Director 86 Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director PA Allegheny Pittsburgh 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 531 Barclay Avenue 15221 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black. White, etc. than "natural", or Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🎇 No Specify: White 3 X Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Homemaker Domestic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Holosko Katherine Kovac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert M. Robinson / Son 531 Barclay Avenue, Pittsburgh, PA 15221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jefferson Menorial
Park 1 X Burial 2 ☐ Cremation 3 X Removal from State Pittsburgh, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death SUBARACH NOID Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Basilar Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence ou and -transit Exam Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buna Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Candrac AVEST ASY STULE 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed or Attending Physician: The 2 🗆 No 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2-1 No 1 Tes ဂ္ဂ 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Hospital Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете 3 🗆 To the I within 2. To the F 29b. Signature and title of certifie completed cause of death (Item 23a) (Type, Print) ENSE

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Records,

Division of Vital

la 1

JUN 3 0 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AROLD Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
72 yrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 218-36-5354 Director 10^MTH P1^y9³⁷ MD Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 16B 2 Spa Creek Landing 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after White 1 Yes XX No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Union Rep/Director Labor Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Thompson Shaw Ida Mae Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Ann Shaw Wife 16 B 2 Spa Creek Landing Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) injury or 1 Burial XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 6/29/2010 Glen Burnie, MD 21. Signarde of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the A ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year 2 🗌 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 124 hours after death.
 Funeral Director: After this certificate h performed' 2 🗌 No Yes 2 Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 Z No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 1. Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Detailing Prijasioan. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Detailing Prijasioan. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who concluded cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

D 21438

NSE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydieneo O t O

		1	For State Of Wise Registrar	Cen	tificate of De	eath		g. No.	1 U	22210
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Samdaye Samaroo				2. Date of Death Jumen 26,		Year	3. Time of Death 11:35 P M
	Medic Examin		la. Facility Name (if not institution, give street and number)		4b. City, Town, or L Silver S			4c. County		
y -	Funeral		Holy Cross Hospital. 5. Social Security Number 6. Sex 7. Age 7. Age	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth		g. Birth	place (State or Foreign
	Director	-	n/a 1 □ M 2 🕅 F	65 Yrs.	Wortus Days	Tiours IVIII.	Jamestry ^a 6	,••1945	11:11	relau
	yland -f show ed at	cto	Maryland Montgomery	10c. City, Town or Loc Silver Spri					1	0d. Inside City Limits 1 Yes 2 No
	the Mar or 28a e notifi	Dire	10e. Street and Number	D2110 - P-	10f. Zip Code		1	0g. Citizen of		ntry?
	ath with	Funeral Director	11438 Lockwood Drive # 304 11. Marital Status 12. Was Decedent E	ver in U.S. 13. V	20904 Vas Decedent of His f Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-	Trinida 14. Rad	e - Americ	can Indian,
36	be filed within 72 hours after death with the Maryland ental Hygiene. Ked olthygiene. Ked olthygiene. Red other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes, Give Year or Dates.		f Yes, specify Cuban ☐ Yes 2 🏋 No		Rican, etc.)	Bla Specify	ck, White,	etc. East Asian
2-00	2 hours "naturs edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupat kind of work done du O NOT use retired)	tion uring most of working	ng	16b. Kind of E	Business In	dustry
2121	within 7 giene. er than , the M		Elementary/Seconday (0-12) College (1-4 or 5		maker			Own Hon		
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Durga Persad			18. Mother's Name Sumaria	(First, Middle, M Jadonan		ne)	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed Department of Health and Mentral H Important: If item 27 is marked of any injury or other traumatic even once.		19a. Informant's Name/Relationship (Type, Print) Sahadeo Samaroo- Husband		ng Address (Street ar Katwaroo Tra			City or Town,	State, Zip	Code)
re, l	1 and 2 of Healtl Fitem 2 r other 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo	sition (Name of matory or other place	,	ate	20c. Location	-	
<u>ti</u>	nit. Page artment ortant: I injury o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funenal Service Licensee	Balt Wash	Crematory Nacka Publica			Laurel,	Mary	and
Ba	permit Depar Impor any in	1 1	Mgh mo1234		7601 Sandy	Spring Rd.	, Laurel,		d 2070	
	Pnysician/	15 A	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final	I the death. Do not ente e. IV Small Cel			r respiratory arre	St,		Approximate Interval Between Onset and Death
	Medical Examiner		disease of condition	a consequence of):						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence city:						
	icate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or linjury	a consequence of):					-+	
760	ate be ex hysiciar the buris	dical	d							
(687	eath certifice attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth	of pregnancy	☐ Ectopic pregnanc	У			ate of deli	
. Box 68	re death	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant a 9 Unknown	at time of death 5	Other (specify)			IV	onth	Day Year
Division of Vital Records, P.O.	or Attending Physician; The law requires that the death certificate be executed frer death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	ğ	Part II. Other significant conditions contributing to death t	out not resulting in the o	underlying cause giv	en in Part I.				the cause of death?
ords	w requir is been s 2 should	Completed					24a, Was a autop	sy	prior to c	opsy findings available ompletion of cause of
I Rec	n; The la ficate ha or, page		25. Was case referred to medical		26. Pla	ace of Death (Chec	perfor 1 ☐ Yes k only one)	2 No	death? 1 Yes	2 No
Vita	nysicia iis certi directo	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpat	ient 2 K ER/Outpatie		er: 4 🗆 Nursing Ho	ome 5 Resid			fy)
n of	nding Pf tth. : After th e funeral		27. Manner of Death 1 🕅 Natural 5 🗆 Pending 2 🗀 Accident Investigation		work		28d. Describe ho	ow injury occu	irred	
ivisic	or Atter after des Director in by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (S City or Town	treet and Num n, State)	ber or Rui	al Route Number,
Ω	To the Hospital or Attending Physician; The law require within 24 hours after death. To the Funeral Director, Affer this certificate has been si completed filled in by the funeral director, page 2 should	Medical	29a. Certifier 1 X Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of	evamination and/or inve	stigation in my opinic	on, death occurred a	t the time, date a	nd blace, and (due to the t	ause(s) and mariner stated.
	To the I within 2 To the I comple	ĕ	only one) 3 Certifying Nurse Practioner: To the		29c. License			29d. Date sigr	ned (Month	, Day, Year)
			> yllegus	20	D69288	3		June 2	8, 201	0
	5h		30. Name and address of person who completed cause of Yodit Negusse, 1500 Forest (death (Item 23a) (Type, Glen Rd, Silve	er Spring, N	4D				
	Sta Registi	ate	31. Date filed (Month, Day) et al. 2010 32. Regist	rar's Signature	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 22279 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 25. 2010 1824P M Gary Nathan Stein 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Chester River Hospital Center Chestertown Kent Social Security Number 6. Sex 1 ☐XM 2 ☐ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min Month, Day, 72/194 175-38-0775 63 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Kent Rock Hall 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 Mercer Ave 21661 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Vietnam Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Tooling Engineer Aircraft Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy E. Temple Jacob Ephram Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 Elk Ridge Rd. Oxford, PA 19363 Christopher Stein/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/1/2010 hesapeake Cremation Stevensville, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home marino 1 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line ArteroScleratic Cardio Vascular Disease Immediate Cause (Final Onset and Death disease or condition resulting in death) 400KS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence on) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year 4 Pregnant : 9 Unknown Pregnant at time of death Day Yes 9 | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? & Rogalfailure on Dialy 1 Yes 24 No 3 Probably 4 Unknown Porphorel Vascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 1 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending

the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 Director: After this certificate has I æ 은 Certificate:

Physician/

Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after obpartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir

Physician

Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

Natural Accident Suicide

4 Homicide

28a. Date of injury (Month, Day, Year) Investigation

injury

28c. Injury at work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 □ Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D0050996

29d, Date signed (Month, Day, Year) 2010

MID

6 Could not be

determined

100 Brown St. Chastortown MD Deil Staddard

31. Date filed (Month, Day, Year) 32. Registrar's Signature forthe

State Registrar DHMH 17 Rev 7/2009

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within 24 hours a

To the Funeral D

completed filled i

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22280 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day 2010^{Year} June 26 Helen Saunders Spence 1545 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death Caroline Nursing Home, Caroline Inc. Denton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 □ F Days Hours Min Month, Day, Ye November 28 Maryland Months Director 221-14-0202 86 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 116 Siesta Drive 21629 United States of America 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give Specify: 3 □xWidowed 4 □ Divorced Completed Caucasian Year or Dates ed other than "natu event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 11 Hs Grad Child Care permit. Page 1 and 2 should be filed will Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, traumetic event, event marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Desmond Marvel, Sr. Saunders Frances Lvdia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank L. Slaughter Son 27517 Substation Road, Denton, Maryland 21629-2860 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 6/30/2010 Denton, Maryland Denton Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Moore Funeral Home, P.A. South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician w 50 200 disease or condition Medical resulting in death) Die to (or as a consequence of): Examiner CV3 Sequentially list conditions if any leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ď Month Year Pregnant at time of death Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? certificate 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 2 Accident 1 Natural 5 Pending work' within 24 hours after death. To the Funeral Director: A 1 Tes 2 No Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29b. Signature 29d. Date signed (Month, Day, Year) D005325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Preston MD 31. Date filed (Month, Day, Year) 32. Registrar's State JUN 2 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUNE 26 Pay 201[°]0° SIMMONS 12:00PM STEWART LEE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHARLES WALDORF 11924 MONTGOMERY LANE | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NEC _ 15,1941 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) MARYLAND 466-66-0032 68 DEC. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location WALDORF MD CHARLES 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 11924 MONTGOMERY LANE 20602 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 9 6 4 1 Wes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Wes 2 No to to Year or Dates: 1966 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛚 No 3 ☐ Widowed ♣ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) AMTRACK Elementary/Secondary (0-12) College (1-4or 5+) YARD ENGINEER (UNION STATION) 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDNA OREAN CARTER SIMMONS ROLLAND L. SIMMONS, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROLLAND L. SIMMONS, JR. (BROTHER) 23089 521 LAKE POINTE TRAIL, LANEXA, 20b. Place of Disposition (Name of cemetery, crematory or other plance of CREMATORY Date 20c. Location - City or Town, State 20a. Method of Disposition JUNE 30, 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD 2010 21. Signare of Funeral Service Licenside (#M00993) TERRENCE L. JOHNSON TERRENCE L. JOHNSON FUNERAL SERVICE, PA 4433 WHITE PLAINS LANE, WHITE PLAINS, MD 23a. Part 1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (et consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∏Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f sh

r than "natural", or items 23a or the Medical Expedit or must be filed within 72 hours after death with

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygle Important: If item 27 is marked other th any hiury or other traumatic event, the

Director

Funeral

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Completed

Be

the Maryland

21215-0036

Baltimore, Maryland

P.O. Box 68760.

of Vital Records,

Division

or Attending Physician:

Examine burial-tran physician the attending for use as signed by the a certificate has been sign irector, page 2 should be director. this

24 hours after death.
Funeral Director: After thi etely filled in by the funeral.

Physician/Medical 2 Completed Be မ Medical Certification:

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

To the within 2

State Registrar 29b. Signature and tive of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number 519947

🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POST OFFICE Rd \$ 100 WALDORF, MD 20100 GONSAIVES, MD.

31. Date filed (Month, Day, Year)

JUL 0 1 2010

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 06 2010 2242PM Theresa L. Stoudmire 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death PANSULA REGIONAL *≾0/1841/4* Hicamica If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-12-1931 1 □ M 2 💢 F Months Days Hours Min 217-28-4063 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Pocomoke Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21851 USA 502 Bonneville Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Specify:Black 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Campbell Soup Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irving Teagle Frances Ginn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Stoudmire/Son 502 Bonneville Ave, Pocomoke, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other blace) 20c, Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Direct Cremation, 7/6/2010 Dover, DE ature of Fun al Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury, Funeral Home 23a. Part 1. Enter the disease shock, or heart failure l e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death List only one cause on each line. Immediate Cause (Final Severe disease or condition resulting in death) Due to (or as a consequence o): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death v

72 hours after

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than '

other traumatic event,

any injury or conce.

Baltimore, Maryland 21215-0036

Examine burial-tran attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be the as use for been signed by the should be detached þ Medical Certificate: To Be Completed has page 2 s certificate completed filled in by the funeral director, this thin 24 hours after death. the Funeral Director: After

IE EEMALE

Division of Vital Records, P.O. Box 68760

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art II. Other significant condition:	s contributing to death	but not resulting in th	e underlying cause give	en in Part

		performed? death?
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.								
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated								
only one)									
29b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						

		l .	
30. Name and addre	ss of j	person who completed cause of death (Item 23a) (Type, Prin	11
,		person who completed cause of death (Item 23a) (Type, Prin	

100 E. CARROLL ST.

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22283 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month じいを 2010 Carol Ann Louise Staubs 4:15PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) uly 20,1939 1 □ M 2 🔀 F 220-34-0284 July 70 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Virginia 1 Yes 2X No Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 623 Nestle Quarry Rd. 25419 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify. 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Jesse Witmer Lola Irene Brillhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Jainniney - Daughter 2659 Grade Rd. Falling Waters, West Virginia 25419 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) July 3,2010 Falling Waters, Virginia Doquation 5 Other (Specify) Harmony Cemetery of Funeral Septide License Signature OSBOTTE AFUREITATIV Home, P.A. 425 S. Conococheaque St.Williamsport, MD 21795 Fat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Esophageat cancer disease or condition resulting in death) Due to (r as a con equence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):

Physician/ Medical **Examiner**

Physician/

Medical

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Director

Funeral

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27 is mar ed other than "natural", or items 23a or 28a-f sho traumati event, the Medical Examiner must be notified at

Il Hygiene. other than "

permit. Page 1 and 2 should e filed Department of Health and Mcntal H Important: If item 27 is mar ed ot any injury or other traumati. even

e filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Box 68760 P.O. I Records, page **Division of Vital** within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral

Be Completed by Physician/Medical Examiner

Certificate: To

Medical

Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year					
Arrial Fibr	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
Dehy drail	an	24a. Was an autopsy performed? 1 \[\subseteq \text{ Yes} \ 2 \subseteq \text{ No} \] 24b. Were autopsy findings available prior to completion of cause of death? 1 \[\subseteq \text{ Yes} \ 2 \subseteq \text{ No} \] 1 \[\subseteq \text{ Yes} \ 2 \subseteq \text{ No} \]					
25. Was case referred to medical	26. Place of Death (Check on	ly one)					
examiner? 1 Yes 2 No	tospital: 1						
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 \[Yes 2 \] No	. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not to determined	280 Diago of Injuny At home form etreet factory office	Location (Street and Number or Rural Route Number, City or Town, State)					
(Check 2 Medical Exam	vsician: To the best of my knowledge, death occured at the time, date and place, and dr niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time Practicuper. To the best of my knowledge, death procured at the time, date and place.	time, date and place, and due to the cause(s) and manner stated.					

29c. License number

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29d. Date signed (Month. Dav. Year)

2010

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the

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

CENCISCO

Daniels 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	ryiano		tificate of			лептат пу	Reg. No	2010	2228	4
Phys			1. Decedent's Name (First, Middle, Las William Woonsik							2. Date of De Month June		2010 Year	3. Time of Death 4:25 P	
	Medical Examiner 4a. Facility Name (if not institution, give street and number)						4b. City, Town, or Location of Death 4c. County of Death					th		
Fune	eral		Social Security Number 6. Se						er 24 Hrs.	8. Date of Bir	th	Montgo		ign
Direc	tor		219-84-0619 13 Usual Residence of Decedent	Yrs.	Months Day	s Hours	Min.	(Month, Da 7/08/	y, Yea <i>r)</i> 194	8 S.	rthplace (State or Forei buntry) Korea			
Maryland 28a-f show	ouried at	Director	10a. State 10b. County Montgoi		10c. City,	Town or Loc ilver	sprir	ıg					10d. Inside City Limi 1 ☐ Yes 2	
death with the Maryland	nust be n	Funeral D	10e. Street and Number 14724 Corona					905				tizen of What Co USA	ountry?	
ING 21215-0036 Filled within 72 hours after death with the Maryland tral Hygiene. ad other than "natural", or items 23a or 28a-f show	al Examiner	출	11. Marital Status 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.			/as Decedent or Yes, specify Cu			ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: AS	e, etc.	
715-10-17	Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)	de completed)		(Give k	ent's Usual Occ ind of work don NOT use retire	e durina mo	ost of work	ing	16b. K	ind of Business	Industry	-8
d withir lyglene	n, me	0)		College (1-4 or 5+	<u></u>	Au	tomobi					utomok	oile	
ylanc ylanc lid be file Mental H narked of	ilc eve	입	17. Father's Name (First, Middle, Last) Byung Sung Su	k						e (First, Middle, 1 Lee	Maiden	Surname)		
Mar 2 shou Ith and 27 is m	omer traumatic		19a. Informant's Name/Relationship (Ty Young Su Suk/W			19b. Mailin	g Address (Stre	et and Num	ber or Rura Prive	Route Number	er, City or Er S	Town, State, Zi Spring	p Code) Md.20905	
Baltimore, permit. Page 1 and Department of Hea Important: If item	lany or our		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	20b. Pla Pa:	ce of Dispos metery, crem rklaw	sition (Name of atory or other p 'n Mem	Pk.	7/01) 2010	20c. Le Ro	ocation - City or	*	
permit Depart Import	once,		21. Signature of the negal Service Lice of			PH 92	Tamerary Ada 41 Col	RTN umbi	AYLDI a Bl	FUNER	RAL lver	SERVIC Sprin	CE,P.A. ng,Md2091	0
Pnysici	anv i		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.		Do not enter	r the mode of d	ying, such a	as cardiac o	or respiratory ar			Approximate Interval Between Onset and Death	
Medi Exami	ical		resulting in death)	a. METASTATIC LUNG CANCER Due to (or as a consequence of):						10 10001	17.2			
L pa .t		miner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury											
be execursician and		ical Exa	that initiated events resulting in death) Last Due to (or as a consequence of):											
oor of the search of the searc		Med	IF FEMALE:	Oge Have entered of	,									
Box 68/60 The death certificate by the attending physiched for use as the property of the period of the peri		Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	☐ Fetal o	death 3 🗌	Ectopic pregna Other (specify)					23d. Date of de Month	llivery Day Year	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director hane? Should be detached for use as the bruist-transit		<u>6</u>	Part II. Other significant conditions of	ontributing to death but	t not result	ting in the ur	nderlying cause	given in Pa	rt I.	23e. Did t	/		o the cause of death? Probably 4 \(\square\) Unknow	wn
The law requires are has been signance?		Completed								24a. Was auto perfo	psy ormed?	prior to death?	itopsy findings available completion of cause of section 2 \square No	le f
VITAL ysician; s certifical		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:			I	Place of De	eath (Check					
TSION OT VITAL MECON Attending Physician; The law er death. Sector, After this certificate has by the fineral director, nade 2, by the fineral director, nade 2, by the fineral director, nade 2, by the fineral director.		sate: To	27. Manner of Death 1 Natural 5 ☐ Pending	1 Inpatier 28a. Date of injury (Month, Day,	2	R/Outpatient 8b. Time of injury	28c. In	ury at ork?		me 5 Resi		Other (Specty occurred	eify)	
JIVISION OT I or Attending PI s after death. I Director: After the		Certificate	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e, farm, stre	M 1 Ves 2 No seet, factory, office 28f. Location (8 City or Tow			Street and Number or Rural Route Number, vn, State)						
To the Hospital or within 24 hours aft To the Funeral Disconniered filled in		Medical	(Check 2 \(\sumeq\) Medical Exami	ician: To the best of m ner: On the basis of exa e Practioner: To the be	mination a	and/or investi-	gation, in my op	inion, death	occurred at	the time, date a	and place	and due to the	cause(s) and manner sta	ated.
T vithi T of the second			29b. Signature and title of certifier	au	J.D.	1		nse number		OK	29d. Da	te signed (Mont	h, Day, Year)	
•			30. Name and address of person who c Raffit Hassan			10	Center	Drive	e, Bet	hesda,	Mar	yland	20892	
	State istra		31. Date filed (Month, Day, Year)	32. Registrar	s Signatur	· faces	J.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ rusty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ent ester 0 If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Social Security Number 6. Sex If Under 1 Year 8. Date of Birth **Funeral** (Month, Day, 1 XM 2 - F Min 3 46 3 **Director** Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important I filem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No towr 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21620 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Ś 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) ၀ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lic 22. Name and Address of Facility Pan . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care lac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) cance Medical Due to (or a consequence of) Elzel Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): as been signed by the attending physician and 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed page death? 2 🗌 No 1 Yes 25. Was case referred to medical **Division of Vital** completed filled in by the funeral director, æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: At 1 \sum Yes 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ρ Name and address of person who completed cause of death (Item 23a) (Type, Print) Family Medicipe

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22286 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 0910 4 Month **Physician** 2010 Thompson 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ent Chestertain Nursing + Rehab. Cente If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 68/)8/1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days Hours 1 M 2 F 81 213-22-518 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Modical Examinar must be notified at 1 XYes 2 No MD Kent Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21620 415 Moranec Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Dolo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Peges 1 end 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. and tempt it it item 27 ie marked other than "natural", or ite 1 □ Yes 2000 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker 12 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be rown mmons ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21620 eskertown ross Daughter 090 Date 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation ŏ 2010 town. permit. Pege Department of important: it eny injury or once. UM 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee nnie Approximate Interva Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter to mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) days Physician 21 /Medical Dugy (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed nmini Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? cete has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes certificate 26. Place of Death Check on o director, Be 25. Was case referred to medical examiner 1 Yes 2 Hospital: Other: 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 2 24 hours efter death.

Funeral Director: After this death filled in by the funeral directoral director. 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury a Work? 28b. Time of 27. Manner of Death Certification: Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the desired form of the desi 29a. Certifier Medical (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of pertifier a 2 pleted cause of death (Item 23a) (Type, Print) and address of person who cop

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

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MIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State o	of Marylan	-		Health and I		0.0	110	00007	
			Registrar 1. Decedent's Name (First, Middle,	Certificate of Death					2. Date of Deat	eg. No.		3. Time of Death	
	Physicia	an	Harriet Miriam				Month	Day	ay Year				
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	or Location of Deat				00 10 11	
e i	LXaiiiii	CI	Envoy of Denton				Denton			Car	oline		
	Funeral			. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Coun		
	Director		216-18-2761 Usual Residence of Decedent	10111201	8	37 Yrs.			June 6,	1923	Mary	Land	
	land ow		10a. State 10b. County	-	10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits	
	Mary P-f sh	tor	Maryland Carol	ine		Green	sboro					1 Aves 2 No	
	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Coun	try?	
	23a		307 N. Academy				2163			U.S.A			
	er dez	Funeral	11. Marital Status	Armed Fo		l.S. 13. \	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S oan, Mexican, Pueri	specify Yes or No- to Rican, etc.)		ce - Americ ick, White, e		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat result be rediffied at once.	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d l∐Yes If Yes, G Year or [1 □Yes 2 No	Specify:		Specia	^{fy:} Whi	te	
Maryland 21215-0036	2 hou atura	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation		16b. Kind of E			
215	hin 72 e. an "n	Jple	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	life.	KING OF WORK GONE DO NOT use retire	during most of wor ed)					
7	ed wit ygien ier th	Completed	11			В	ookkeepe		ere en helendele e	Banki			
gu	be filk	Be	17. Father's Name (First, Middle, Last)						me (First, Middle, i		те)		
3	d Mer narke	P	Edward W. Lapha					ed Seward	Code)				
<u>⊠</u>	d 2 sh Ith an 17 is r traur	1	19a. Informant's Name/Relationship Robert A. Thorn		Lenouse						1639	, , , , , , , , , , , , , , , , , , , ,	
ē,	f Heal	18	20a. Method of Disposition	.com, or .	20h	Place of Dispo	sition (Name of matory or other pla	i	Date	20c. Location		wn, State	
altimore,	Pages ent of nt: If i		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		i State I	•	-		29.2010	Greens	boro.	Maryland	
ä	mit. I partm sorta / Inju		21. Signature of Funeral Service Li					ess of Eacility nd Helfer					
Ö	Per E Pe		Mark	Flu	yla		06 W. Su	nset Ave	., Greens	boro,	Mary1	and 21639	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omplications that	caused the dea each line.	th. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory ar	rest,		Approximate Interval Between	
in y	Physician	1	Immediate Cause (Final disease or condition resulting in death) a. FACINE & The CBRIGH SPINE Due to (or as a consequence of):									4 DAYS	
	/Medical Examiner	Н	resulting in death)	Due to	(or as a consec	quence of):		To a 10 d. A				4 MAKE	
	Examiner	<u>.</u>	Sequentially list conditions,	b. FALL AND CERVICAL TRAUMA Due to (or as a consequence of):							-	10412	
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	; leading to immediate Due to (or as a consequence or) e. Enter Underlying e (Disease or injury							- 1		
	execu n and al-tra	Exar	that initiated events resulting in death) Last	c Due to	o (or as a consec	quence of):							
8760,	ficate be executed physician and s the burial-transit	dical	1	d									
68	rtifica ng ph	/ledi	IE EENAN E.										
Вох	eath certifi attending I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregr e birth 2□ Fet	al death 3	☐ Ectopic pregnar	ncy			Date of delivery Month Day Year		
О.	e dea the at ned fo	sici	1 ☐ Yes 2 █ No 9 ☐ Unknown	4 □ Pre	gnant at time of known	death 5[Other (specify)						
Р.	that the dened by the detached		Part_II. Other significant condition	s contributing to	death but not re:	sulting in the u	Inderiving cause g	iven in Part I.	23e. Did to	bacco use co	ntribute to t	he cause of death?	
Vital Records,	iires tha signed d be det	d by	DEMENTIA	A					1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Ur				
Sor	w requir been s should	Completed	HUDERTE	KIDNI					24a. Was a	an 24b	. Were auto	opsy findings available	
Be	he law e has ige 2 s	шć	(000MAPV	AOTH	OV DV	14 A	T		_ perfor	autopsy performed?		rior to completion of cause of eath? □Yes 2□No	
ta	ician: The certificate ector, pag		25. Was case referred to medi	/114BI	y Dr	75ND	2-	26. Place of De	1 ☐ Yes eath (Check only o	2 No ne)	i 🗆 res	2 🗆 110	
<u> </u>	Physici this cer al direct	o Be	examiner? 1∰Yes 2 □ No	Hospital: 1	Inpatient 2	☐ ER/Outpatie	nt 3 □ DOA O	ther: 4 Nursing	Home 5 ☐ Resid	lence 6 🗆 O	ther (Speci	ify)	
0 4	Attending Physician: The lar ar death. ector: After this certificate has by the funeral director, page 2	L: Ľ	27. Manner of Death 1 □ Natural 5 □ Pending	(8.80)	e of Injury inth, Day,[Year)	28b. Time o	of 28c. Inj	ury at ork?	28d. Describe h	ow injury occu	urred		
Siol	eath. or: A the fu	catic	2 Accident investiga	ation C6	23/201		71	□Yes 2 No	FALL				
Division of	for Attendater death Director:	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 26e. Fig.	ding, etc. (Spec	cify)	reet, factory, office	9	28t. Location (S	Street and Num		ral Rozin Buziner	
	pital ours a eral C		29a. Certifier 1 ☐ Certifying		Way, No			time, date and place	ce, and due to the	cause(s) and		stated.	
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending in completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)	xaminer: On the	basis of examir nner stated.	nation and/or i	nvestigation, in my	opinion, death occ	curred at the time.	date and place	e, and due i	to the cause(s)	
	of the vithin To the complex c	Me	296 Michalland Stephen	sege W	10		29c. Lice	14664 nse number		06/2 29d. Vate sign			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Marv Frances Turner June 8:24 PM 27 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homestead Manor Denton Caroline If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 F 215-01-0116 89 May 9. Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Marvland Caroline Ridgely 1 ☐ Yes 2.☐ No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or it a or 24029 Meadows Drive 21660 United Statesof America "natural", or items 23a Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 H No 3altimore, Maryland 21215-0036 Specify: Caucasian þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Wallpaper & Paint store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Wesley Thorpe Lyda Dickerson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki King Daughter 24029 Meadows Drive, Ridgely, Maryland 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesterfield Cemetery 7/1/2010 Centreville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Renal cell resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and Due to (or as a consequence of): attending physician are for use as the burial-t Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 153.578 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 eritfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Mel·nda

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

00053255

Lan Ave Preston MD 21655

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Butter

055

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Marie Taylor 28 Ethel June 2010 11:11/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Home for Hospice Caroline Denton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🔽 F Months Days Hours January 29, 1909 California Director 213-24-2520 101 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, I've Modical Examiner must be redified at 1 X Yes 2 □ No Director Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 908D 21629 UnitedStates of America Gav Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examires mass. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status ☐Yes 2 Yes, Give 1 Never Married 2 Married 2√ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: Caucasian \$ 3 Wildowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angeline Chowning 2 James Barrett Patton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty Taylor 201 Maple Way, Salisbury, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friendship Cemetery 7/2/2010 Preston, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Synature of Funeral Service Li 12 South Second Street, Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? 1 □Yes 2 🗷 No Month Day Year 5 Other (specify) the 9 T Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed CHOLELITHIASIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 No Division of Vital 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Control Other (Specify Hospice 1 Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA House 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Certification: Injury at Work? 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation Director: d in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title 00063063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Rualo, M.D., 609 Daffin Lane, Denton, Maryland 21629
32. Figistrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amended #28c per FH, RG FCHD 6/30/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ ^{Day} 2010 Glen L. Tayler 0:35 A. M June 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Golden Living Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1**x** M 2 □ F Months Days Hours Min July 8, Utah 74 Director ปี935 529-40-4356 Usual Residence of Decedent 28a-f show 10a. State 10h County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21702 USA 6385 Overbrook Circle death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify: white Specify: Completed 3 ₩ Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Dept of Energy Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucille Leonard Clarence Henry Tayler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
232 Shannonbrook Lane, Frederick, Maryland 21702 Lyle Tayler - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Redwood Memorial 7-3-2010 Salt Lake City, Utah 21. Sign ture of Funeral Service Livensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland elu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, DISEASE shock, or heart failure. List only one cause on each line Immediate Cause (Final THEROSCLEROSIS CORONARY ARTERY Onset and Death Physician/ disease or condition resulting in death) Medical Examiner ROSTATE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practical Cortifying (Check 29b. Signature and title of certifier 2010 20061410 MD

Registrar
DHMH 17 Rev 7/2009

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TOLL HOUSE AVE, FREDERICK MD

21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801

32. Registrar's Signature

1 Baselina

SYED

GAFFAR

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Physician/ June 28 William Lewis Taylor 11:10 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Oct. 4. T931 New York Director 120-24-2193 78 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No DC Washington None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 1325 Iris Street. 20012 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Specify: Year or Dates. 56-57 White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5**+ Private Law Practice Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Levine Harru Taulor Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Tulip Avenue, Takoma Park, MD Lauren Rose Taylor. daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lebanon Cemetery 6/30/2010 Adelphi, Maryland Mt. 21. Signature of Juneral Service Licen 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00709 1800 New Hampshire Ave. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, story one cause on each line. Approximate
Interval Between
Onset and Death auyImmediate Cause (Final Physician/ Aspiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): pmo Examiner Subdural hematoma 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): 1 month To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the himseld infector, page 2 should be detached for use as the burial-transit Subarachnoid hemorrhage attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical 1 month Head Trauma ision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death Yes 2 ☐ No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a, Was an Director: After this certificate has a n by the funeral director, page 2 s autopsy performed? Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year, Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 💢 No May 26, 2010 Unknown Tripped and fell Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Street 28f. Location (Street and Number or Rural Route Number, determined washington, DC Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficiency in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D67986 June 28, 2010

Registrar

DHMH 17 Rev 7/2009

State

20814

Yuneng Li, M.D., 8600 Old Georgetown Road, Bethesda, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 1 2010

31. Date filed (Month, Day, Year)

To the Hospital o within 24 hours af To the Funeral D

State Registrar

DHMH 17 Rev 1/2001

OCME 2006

Medical

29b Signature and title of certifier

Carol Allan, MD

lot

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

allai

recha

2. Registrar's Signature

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Helen L. Vernon 26 8:05 PM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bedford Court Nursing Home Spring If Under 24 H Silver Montgomery 9. Birthplace (State or Foreign Social Security Number . Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2**X**□ F Months Days Hours Min (Month, Day, Year) Country Director 220-28-5316 98 July 8, 1911 Illinois Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 XNo Ma<u>ryland</u> Silver Spring Montgomery 10e. Street and Number ō 10g, Citizen of What Country? "natural", or items 23a o Funeral 3700 International Dr. 20906 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify. Completed White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) ge 1 and 2 should be filed within 72 it of Health and Mental Hygiene.

If item 27 is marked other than "r or other traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edwin Lines Edna Plummer 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Blaker/Daughter Blondell Ct. Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State ± 5 Department or Important: If any injury or 4 Donation 5 Other (Specify) Lincoln Crematory Jul 2, 2010 Brentwood, 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List of v one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Arteriosclerotic CArdiovascular Disease years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and defacted for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Aortic Valve Disease Completed 1 Yes 2X No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, pag 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: P Other: 2 **X**No 4 Nursing Home 5 Residence 6 Nother Asst. Living 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a, Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL

James A. Rossi, M.D.,

01 2010

BM am mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

3305 N. Leisure World Blvd., Silver Spring, MD

D24543

29d. Date signed (Month, Day, Year)

June 29, 2010

20906

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.2010 22294 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wilson Month Physician/ Day 930 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9 Pennsylvania Avenue Edgewater Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9/26/1944 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Min Washington. Director 216-42-9742 65 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland | Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Pennsylvania Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Medica1 vears Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Susie E. Kettner Ernest A. Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven C. Wilson/ Husband 9 Pennsylvania Avenue, Edgewater, Maryland 21037 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 06/30/2010 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory Edgewater, Maryland 21. Signature of Tangera 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami the attending physician and the for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tuneral director, page 2 should be dei Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death?
1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5, Residence 6 Other (Specify) 2 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 \square Pending work? 2 🗌 No ☐ Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI. 6/28/2010 9W Bestz te Rd Sute 300 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) 100 Jai 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

			State of Maryland / Department of Health and Mental Hygiene	•			
			, For	2010 22295			
	Physici /Medic		1118/6 1/				
The same of the sa	Examir		er 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. CIVISTA MEDICAL CENTER 4c.	Charles			
	Funeral Director		5. Social Security Number 245-84-7776 6. Sex 1 Months Days Hours Min. 1 M 2XX 61 Yrs. 1 Months Days Hours Min. 1 1 - 15 - 194	9. Birthplace (State or Foreign Country) NORTH CAROLINA			
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location NANJEMOY	10d. Inside City Limits 1'⊟Yes 2 🂢 🏌			
	a or 28a-	al Direct	10e. Street and Number 8260 GREENLEEK HILL ROAD 10f. Zip Code UN	itizen of What Country? ITED STATES			
920	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner mast be notified at	Completed by Funeral Director	11. Marital Status 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	14. Race - American Indian, Black, White, etc. SpecifyWHITE			
21215-0036	within 72 ho iene. than "natur he Medical	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEWING/SHOE FACTORY	Gind of Business/Industry PRIVATE			
Maryland 2	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden CRADY DATLY BROWN T.F.ATHTA PARSONS				
, Mary			19a. Informant's Name/Relationship (Type, Print) JOYCE A. ELLER / NIECE 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Number, City of Section 19b. Mailing Address (Street and Number or Rural Route Nu	or Town, State, Zip Code) JEMOY, MD 20662			
Baltimore,	permit, Pages 1 and 2 Department of Health s Important: If item 27 Is any Injury or other tra once.		— cemetery grematory or other place) JIII.Y 01.	.ocation - City or Town, State IVERDALE, MD			
Balt	permit, Depart Import any Inj once.	RAL SERVICE, PA					
E	eath certificate be executed EX Medical Indicate be executed EX The property of the purial transit or use as the burial transit or use as the purial transit	ical Examiner	<u>a</u>	Approximate Interval Between Onset and Death			
P.O. Box 68	Physician: The law requires that the death certificat this certificate has been signed by the attending phy rail director, page 2 should be detached for use as the	ıysician/Med	Physician/Medi	nysician/Med	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2 No 9 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown Unknown 2 Unknown 2 Unknown 2 Unknown 2 Unknown	23d. Date of delivery Month Day Year
rds, F	quires that the de en signed by the a uld be detached fi	è	A Part II. Other significant conditions continuously to death but not resulting in the underlying cause given in Part I.	use contribute to the cause of death?			
al Records,	ding Physician: The law requir n. After this certificate has been s funeral director, page 2 should	Completed	24a. Was an autopsy performed? 1 □ Yes 2 AN	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
Vita	rsician s certifi director	o Be		6 Other (Specify)			
Division of Vital	iding Phy th. : After this funeral o	tion: To	27. Magner of Death 1				
Divisi	Hospital or Attend 24 hours after death. Funeral Director: / ately filled in by the fi	Certification: To	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a building, etc. (Specify)	and Number or Rural Route Number, te)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (
	To the I within 2 To the I complet	M	\geq 29b. Signature and title of certifier 29d. Disconsisting D 206 29	late signed (Month, Dat. Year)			
	BB3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEDRGE H. WATHEN, MD, 11345 PEMBROOKE SQUARE, WALDORF, MD	20603			
	Sta Registr		te 31. Date filed (Month, Day, Year) 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ SON no Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12913 Dunkirk Drive Marlboro Upper George's rince 8. Date of Birth

De(Month 2 Day, Year) 40 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Funeral 1**y** M 2 □ F 54 69 224 6103 Virginia Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 √2 Yes 2 □ No Md Prince George' Upper Marlboro 5 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 12913 Dunkirk Drive 20772 US death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 5 Completed by 1 Never Married 2 Married 1 Yes Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic avent. 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Produce Selector Giant Food 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Wilson Irene Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn M. Wilson/wife 12913 Dunkirk Dr. Upper Marlboro, MD20772 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Roosevelt Cemetery 7-6-2010 Chesapeake, VA of Funeral Service Licenses 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 2294 Old Washington Rd Waldorf, MD20601 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of, attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Dav been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has page 2 perform 1 Yes 2 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hone examiner? Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death.

I Director: After to in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred Accident Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours and to the Funeral I Medical 29a. Certifier 😭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title

Registrar
DHMH 17 Rev 7/2009

State

me and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 11:20 PM Cheri Elaine Wheeler 2010 JUN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb 10, 1964 Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2XXI Months Hours 46 Maryland Director 218-90-5452 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Knoxville Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 19708 Harris Hollow Lane 21758 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes XX No Black, White, etc. þ 1 Never Married XX Married Maryland 21215-0036 Specify: White 1 Yes XX No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Rural Carrier U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Marvin Lester Jamison June Evelyn Sigler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Wheeler, Jr. - Husband 19708 Harris Hollow Lane Knoxville, MD 21758 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MX Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other Cedar Lawn Mem. Park :06-29-2010 Hagerstown, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OVARIAN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): death certificate be executed the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifiers 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work 2 Accident
3 Suicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D45813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +3

Registrar DHMH 17 Rev 7/2009

State

JCOTT

WEGNER 29

2H-10

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

32. Egistrar's Signature

11110 medical campus RD STE130 HAGENSTAUNIMO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June Physician/ 4:00 PM Paul Joseph Weisz, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 25. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Idaho 519-38-7929 Director Usual Residence of Decedent 10d, Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 No Maryland Washington County Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 23a Funeral 21742 U.S.A. 13060 Hawkins Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No.
If Yes, Give 1962
Year or Dates.1997 Black, White, etc. 6 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced the Medical 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) US Government Army Officer Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ၉ Suzanna Zellenkovitch Weisz Thomas Mark Weisz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13060 Hawkins Circle Hagerstown, MD 21742 Gloria Elizabeth Weisz-wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Arlington National Cemetery 1 X Burial 2 Cremation 3 Removal from State 7-21-2010 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home . Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 5 Vear disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA ၉ funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After is completed filled in by the funeral 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 68995 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) t, Hagerstown Yon9 31. Date filed (Month gistrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 2:20p M Paul Anthony Wabik 2010 Medical Iune 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Montgomery General Hospital Olney Social Security Number 052-54-4242 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min June, 22 Year 1957 NewtryYork Director 53 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 20905 15025 Whitegate Road **USA** items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 Black. White, etc. 0 Completed by 1 Never Married 2 Married 2 🗆 No 1 ☐ Yes 2 No Specify: Year or Dates. 1975-79 "natural", Specify: Caucasian 3 Widowed 4 XDivorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Programer Information Technology Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Irene Pieczynski Anthony Wabik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, MD 20905 15025 Whitegate Road, Kimberly Wabik- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 07/01/2010 Rockville, Maryland Parklawn Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Euroral Service Licensee 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc 11800 New Hampshire Ave, Silver Spring Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final SUSPECTED DIFFUSE METASTATIC CANCER Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of ig physician and as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INTESTINAL BLEEDING, DISSEMINATED INTRAVASCULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? COAGULATION, PNULMONIA, RESPIRATORY FAILURE, RENAL 24a. Was an autopsy performed? Yes 2 No FAILURE 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 M Inpatient 2 ER/Outpatient 3 DOA 27. Mannes of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

that the death certificate be execu-OLP PL M.C. of Vital Records, P.O. Box 68760 or Attending Physician; 24 hours after death Funeral Director: A Hospital npleted within 24 the

101

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

H0065661

27/2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

012010

STEN, D.O. 18101 Prince Philip Drive, Olney MD DEBORAH

Registrar's Signature

State Registrar

Medical

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29^{Day} JUNE Physician/ 2010 12:50P M MARION MARFY YOUNG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY ROCKVILLE CASEY HOUSE HOSPICE 8. Date of Birth (Month, Day, 1 2 / 3 1 / 9. Birthplace (State or Foreign Country) WI If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Days 88 Director 392-14-0408 Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f shov her must be notified at 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 X Yes 2 No MONTGOMERY POOLESVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 20837 20017 HALLER AVE. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. ıral", or iten I Examiner n Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc Completed by 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 💢 No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates "natural", 3 Widowed 4 □ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) **PSYCHOLOGY** Elementary/Seconday (0-12) College (1-4 or 5+) CLINICAL 27 is marked other the traumatic event, the PSYCHOLOGIST Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ MARY EUGENIA SZABO JULIUS JOSEPH MARFY permit. Page 1 and 2 should be Department of Health and Men. Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code2083719a. Informant's Name/Relationship (Type, Print) 17206 SPATES HILL RD., POOLESVILLE, JULIE SANCHEZ / DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State PARKLAWN CEMETERY 07/06/2010 ROCKVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licens 22. Name and Address of Facility P.O. BOXHILTON FUNERAL HOME BARNESVILLE, Approximate Interval Between 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ BLADDER CANCER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s 1 ☐ Yes 2 ☐ No certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

NICOLE CHRISTENSON,

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c, License number

R120698

CRNP 6001 MUNCASTER MILL RD.,

29d. Date signed (Month, Day, Year) JUNE 29, 2010

ROCKVILLE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 17, 2010 Physician/ Robin Bishop Allen 3:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 7805 English Way Bethesda Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1944 1 □ M 2 🕅 F March 29 Months Days Hours 66 296-42-5377 Missouri Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 20817 United States 7805 English Way hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married 2 Maryland 21215-0036 e filed within 72 hours after tal Hygiene. ed other than "natural", o 1 Yes 2 No Specify. If Yes Give White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Social Worker Adoption Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Mary Lucille York Kenneth L. Bishop permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7805 English Way, Bethesda, Maryland Dwight L. Allen, Jr./Husband Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State JulyPat19. 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2010 Bethesda, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home,
7557 Wisconsin Avenue, Bethesda, Chase, Inc. William M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 172 years Immediate Cause (Final ∤nysician/ Malignant Peritoneal Mesothelioma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Year 5 Other (specify) Day Pregnant at time of death ed by the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate ! Yes 2 X No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 **X** No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A Acciden Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one within 2 To the I the 29c. License number 29d. Date signed (Month, Day, Year) July 18, 2010 D0043361

State Registrar

20

32. Registrar's Signature

2150 Pennsylvania Avenue, NW, Washington, D.C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert S. Siegel, M.D.

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 10 2 2 3 0 2

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day $J_{\mathbf{u}\mathbf{1}\mathbf{v}}^{\mathsf{Month}}$ Physician/ 13 2010 A $^{\mathsf{M}}$ Judith Ε. Alden 9:07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 9600 Newbridge Drive, Rm 223 Potomac 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Days Hours December 11. 1944 New Jersey 150-36-0024 Director 65 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Bethesda Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20816 6006 Onondaga Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Law Firm Attorney Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ٥ Jean Palmedo Theodore Eberhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3133 Adams Mill Road, NW, Washington, D.C. 20010 Kristin Alden /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 18, July 2010 cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda- Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral service License ette 23a. Part 1/Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 9 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 ☐ Yes 2 g 9 ☐ Unknown page 2 should be detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗌 No 2 X No 1 Yes Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗆 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 📈 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending 5919 12 2010 Ust 10 1 Yes 2 No Investigation Accident 3. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State) 4 Homicide Dr determined Hotel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge Signature and title of contifie 29d. Date signed (Month, Day, Year) D 20428 DID Secker MO DOME July 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 524 Hawkesbury Lane, Silver Spring, Maryland 20904 Ira N. Brecher, M.D. 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fth 9905 7-27-10 yt State of Maryland / Department of Health and Mental Hygiene 0 1 0 22303 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Santiago Aguirre 00: 20 AM 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Union Memorial Hospital Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 1920 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Days Hours 90 217-22-3430 June 9 ay, 1910 Director Argentina Usual Residence of Decedent 10b. County N/A Maryland or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho ary injury or other traumatic event, the Medical Examiner must be notified at once. Town or Location Baltimore 10d. Inside City Limits Directo 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 Argentina 3014 Guilford Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Hispanic 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 √2 Yes 2 □ No Specify: Argentinian 3 🔽 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Operating Engineers Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print)

Isabel Moniodis/Daughter 19b Mailing Address (Street and Number or Bural Boute Number City of Toyn, State 356 Code)
7919 A Belridge Road Baltimore Maryland 21236 Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 \square Burial 2 \bigcirc Cremation 3 \square Removal from State 4 \square Donation 5 \square Other (Specify) cemetery, crematory or other place) 7/19/10 Hilltop Service Corp. Towson Maryland 21. Si ratur of Funeral Service Licensee Leonard discussoff Facility Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
2 Lays Immediate Cause (Final Prysician Gastroin-testinal disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to minociate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the bunal-translt To the Hospital or Attending Physician: The law requires that the death certificate be executed Ischemic that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Dav should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performe 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier AT 243 89 46

State Registrar MEMORIAL

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

union

32. Registrar's Signature

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filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of N	Maryland	•	rtment of I tificate of I	Health and Death		giene Reg. N. 20	10	22304	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death	
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امر_			Johns Hopkins Bayview Med 5. Social Security Number 6. Sex 7. 17.	lical Ce	nter	Balty If Under 1 Year	Nove If Under 24 Hrs	8. Date of Birt	N/		place (State or Foreign	
	Funeral Director			9	Yrs.	Months Days	Hours Min.	May 30	, Year) 931	Wes	Virginia	
	ind show at	o	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca						10d. Inside City Limits	
	Maryla 28a-f	10a. State 10b. County 10c. City, fown or Location Edgemere 10b. Street and Number 10c. Street and Number 10f. Zip Code 1								1 ☐ Yes 2XXNo		
	vith the 23a or st be n		10e. Street and Number 4629 Green Cove Circle			10f. Zip Code	21219		10g. Citizen of		ntry? States	
	death v items ner mu	Funeral	11. Marital Status 12. Was Deceden Armed Forces		13. W	as Decedent of F Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Ra	ce - Americ	can Indian,	
036	e filed within 72 hours after death with the Maryland tal Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates		1	☐ Yes 2 🖾 No	Specify:		Specif		Thite	
15-0	72 hour	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give ki	ent's Usual Occup ind of work done NOT use retired	during most of wo.	king	16b. Kind of I	3usiness In	ndustry	
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and	oe filed Intal Hy ced oth cevent	To Be	17. Father's Name (First, Middle, Last) Carleton Perry Bell					ne <i>(First, Middl</i> e, Margaret		,		
ary	2 should be file Ith and Mental I 27 is marked c r traumatic eve		19a. Informant's Name/Relationship (Type, Print)	1	19b. Mailing	Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code) and 21219	
e S	and 2 s Health em 27 ther tra		Richard A. Ahern, Jr. (S	<u>,</u>		ition (Name of	ove CIrc.	Date Edge	20c. Location	· ·		
mo	Page 1 nent of int: If it		1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from Sta	- cen	netery, cremi	atory or other pla L1 Mem G	dns. 7/	19/2010		•	Maryland	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr	d	21. Signatur of Funeral Service Licensee	0		Name and Addre da-Ruck 322 Wise	Funeral	Home of	Dundalk Marvlan	Inc. d 21	c. 222	
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	l by Pł	Part II. Other significant conditions contributing to death	n but not result	ting in the un	nderlying cause g	iven in Part I,				the cause of death?	
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Rec	The lav	Com						auto perfo 1 🗆 Yes	ormled? 2 🗱 No	death?	2 No	
Vita	/sician s certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inc.	atient 2 🗆 EF	R/Outpatient	I O++	Place of Death (Che	ck only one) Home 5 □ Resi	dence 6 Ot	her (Specif	(v)	
o t	ing Phy .: Vfter this uneral c		27. Manner of Death 1 Natural 5 Pending (Month, I	njury 2	8b. Time of injury	28c. Inju wor	ry at k?	1	now injury occu		,,	
/ISIO	r Attend ter death rector: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of I building.	njury - At hometc. (Specify)	e, farm, stre	et, factory, office	Yes 2 No	28f. Location (City or Tov		ber or Rura	al Route Number,	
ă	spital o	STORE 29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner										
	the Ho hin 24 h the Fur upleted	Medical	(Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To t	f examination a	ind/or investi	gation, in my opin eath occurred at t	ion, death occurred he time, date and p	at the time, date a	and place, and d ne cause(s) and r	lue to the ca manner as s	ause(s) and manner stated.	
	2 4 4 2 €		29b. Signature and title of certifier			29c. Licens	S = OOA		29d. Date sign	ed (Month,	20) ()	
	8		30. Name and address of person who completed cause o				000		surg	177	1	
	Stat	e.	Bradley Struk M.D. 31. Date filed (Month, Day, Year) 32. Regis	4940 stra 's Signary		rn Avery	ie, Balt	rmore 1	MI) 2	1226	+	
	Registra		JUL 19 2010 Kenny	D. July	* ***							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Items 23artII, 25 per me, 8906, 08/20/2010 dhb

1 - State Per me, 8906, 08/20/2010 dhb

Certificate of Death

Reg. No. 22305 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 2107 ROBERT LEE BATTS JR. Ju1v 2010 Medical a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARFORD CO UPPER CHESAPEAKE HOSPITAL AIR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Hours Min MAR. 16 Year) 1950 PENNSYLVANIA Director 67-42-4774 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo ABINGDON MARYLAND HARFORD CO 10f. Zip Code 10g. Citizen of What Country? Street and Number Funeral U.S.A. 21009 2929 RUSIN CT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces 1 Never Married 2 XMarried 2 🗆 No δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 70/92 1 Yes 2XXNo Specify: Specify: BLACK 3 Widowed 4 Divorced Completed any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. APG WELDER 12vrs 6yrs is marked other Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARIE I MURPHY ROBERT LEE BATTS SR. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 27 2929 Ruskin Ct, Abingdon, Maryland 21009 Joanne Batts/Wife mportant: If item Method of Disposition
1

X Burial 2

☐ Cremation 3
☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 07-23-10 of Funers Service Lie 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A 321 S PHILADELPHIA BLVD, ABERDEEN, MD., 21001 Part 1. Enter the disease, or complications shock, or heart failure. List only one cause omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hour disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner cinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: or Attending Physician: The law requires that the death certificate be executed OVED BY MEDICAL EXAMINE Cause (Disease or linjury burial-tran and that initiated events resulting in death) Last attending physiciar Physician/Medical MEAUUY CERTIFICATION A 9atts Kobertler M%03331 the should be detached for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ . 9 ☐ Unknown signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ungs with 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe completed filled in by the funeral director, page 2 this certificate has Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 2 Accident iniury 5 Pending Investigation 24 hours after death Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the basis of my knowledge, death occurred at the time date and claim to the incurred; and manner as stated. (Check within 2 To the a by one 29c. License number 29b. Signature shd title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Regi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Dorothy Baker 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice
5. Social Security Number 6. Sex Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. (Month, Day, Year) Days Hours 1 □ M 2 🖫 F Months 217-05-7040 91 **Director** 5-17-1919 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 Yes 2 No MD n/a Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 23a or Funeral 2543 Calverton Heights Avenue USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. þ ō 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗙 No Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: African-American "natural" Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Baltimore City Schools Special Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry Jefferson Marv Jefferson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Nathaniel Baker/Son 2543 Calverton Heights Avenue, Baltimore, MD 21216 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Strain 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7-21-2010 Woodalwn, MD 21. Signal e of Funeral Service Licensee 22. Name and Address of Facility Whie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumonia Medical Examiner isarde Sequentially list conditions it any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown iis certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 2 No 4 \Bull Nursing Home 5 \Bull Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending ■ Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No death. Investigation 2 Accident
3 Suicide within 24 hours a er deat To the Funeral Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicíde determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5200 Fast

32. Registrar's Signature

10-05305 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Victoria Lynn Bond State of Maryland / Department of Health and Mental Hygiene 2010 22307 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 15, 2010 Medical Examiner 1350 hrs Victoria Lynn Bond 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 114 Broadway Street **Baltimore** NA 5. Social Security Number 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Foreign Days Months Hours Director 46 1 M 2 F 06-14-64 220-72-7232 Country) DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits l other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. 1XXYes 2 No MD NA Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Broadway Street 114 S. 21231 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 2 X X Married Armed Forces? White etc 1 Never Married 2X X No Yes White 3 Widowed 4 Divorced If Yes, Give Year Yes 2XX No specify: Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 h nent of Health and Mental Hygiene. int: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 12th Grade NΑ Home maker Domestic 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Arthur Η. Loeschner Be Mary Trower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Baltimore, MD William Bond-Husband Broadway Street Baltimore, 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 07-17-10 Catonsville, MD Donation 5 Other Specify 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 638 N. Gilmor Street Baltimore, MD 21217 **Physician** Approximate Interval Between Onset and **IMPortain** Death Immediate Cause (Final disease Hypertensive Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical attending physician or use as the burial -X UNPENDED 23a, pt.II,27 per me g906 8-5-10 vt Box 68760. IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. signed l \$ 1 Yes 2 No 3 Probably 4 Unknown Obesity Completed has been s 2 should l 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene this Inpatient 2 1 V Yes After 1 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Director: d in by the f 5 Pending 1 Yes 2 No death. Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Ø

DHMH 17 Rev 1/2001

OCMF 2006

State Registrar

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 16, 2010

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

dir

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 22308 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ATHERINE BAKER 9:29 PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A HOSPITAL BALTINORE HARBOR CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 M 2 KF Jul 1, 1931 Director 212-28-9507 79 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sl 1 Tes 2 No Maryland Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 613 Hammonds Lane 21225 USA "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Baker Food Service unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Margaret Haynie Page 1 and 2 should be Clearance Rooney other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 926 E. Patapsco Ave., Baltimore, MD 21225 S Belinda Munoz - Granddaughter Health tem 27 item 20b. Place of Disposition (Name of cellhatery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 K Burial 2 Cremation 3 Removal from State 7-22-2010 Crestlawn Mem. Gardens ation Other (Specify) Marriottsville MD 22. Name and Address of Facility AMBROSE FUNERAL HOME OF LANSDOWNH 2719 Hammonds Ferry Rd. Lansdowne MD 21227 Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ RESPIRATORY FAILURE ACUTE disease or condition Medical resulting in death) Examiner CEREBRAL HEMISPHERIC INFARTION ARGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami YPERTENSION attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death certificate has been signed by the a irector, page 2 should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 🛮 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending Investigation
6 Could not be 1 \square Yes 2 🗌 No

P.O. Box 68760 Division of Vital Records, funeral director, hours after death. Ineral Director: After this To the Hospital or Attending within 24 hours after death

To the Funeral Director: A
completed filled in by the f

Baltimore, Maryland 21215-0036

State Registrar

Medical

3001 SOUTH HANDVER STREET BALTIMOR, MD 21225 HAMOUDA 31. Date filed (Month, Day, Year)

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

32. Registrar's Signature

Accident Suicide

29b. Signature and title of certifier

4 Homicide

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RES -

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2010

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Buschman Lillian Dolores 400 14 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FRANKLIN SQUARE Hospital Rosedale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√2 F Months Days Hours 214-44-6271 93 Director March 16,1917 Maryland Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Eventhan context by rutillical at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TXNo Director Baltimore MD Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3755 Proctor Lane 21236 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: ģ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Years Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) timore, Maryland Be Carrie McFaul ည Henry Hamer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Roseanne Kovacsi (Daughter) 3755 Proctor Lane Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 7/16/2010 Dundalk, Maryland 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Duda-Ruck Funeral Home of Dundalk, 23a. Part1. Enter the disease or shock, or hear the List of 7922 Wise Ave. Dundalk, Maryland sease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed pulmonary disease OBSTRUCTIVE attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? €. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 \(Yes \) 2 \(\overline{N} \) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated. 29d. Date signed (Month, Day, Year) $\overrightarrow{J} \circ L , 14, 2010$ 29b. Signature and title of certifier Kottengufil mo D69193 and address of person who completed cause of death (Item 23a) (Type, Print) Cathil 9000 FRANKLIN SQUARE DR BOLLTO Md KottarathiL State Registrar

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10-05180 William Balk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 22310 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3 Time of Death Physician/ Month Day July 10, 2010 William 2028 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Raltimore University Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Foreian Months Hours Director 213-36-8364 Sept. 10 1940 1 X M 2 F 69 country) Mary land Usual Residence of Decedent 10d. Inside City Limits Iny 10c. City, Town or Location 10a. State 10b County Berlin 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. Maryland Worcester permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Framinary. rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 5 Dockside Drive U.S.A. ō Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 Married 1 X Yes White 3 X Widowed 4 Divorced If Yes, Give Year 1960-631 Yes 2 X No specify: Specify: \$ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Police Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick George Balk, Jr. Regina Harman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Howard/ Daughter 3571A Mill Green Road Street, Maryland 9 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, timore, Hilltop Service Corp. 1 Burial 2 Cremation 3 Removal from State 7/17/2010 Towson, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licer 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 Physician /Medical attons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a Part I Enter the disease, or comb failure, List only one cause on each line Between Onset and Death a. Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Deep Venous Thromboses Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the attending physician and led for use as the burial - transi The law requires that the death certificate be executed sician/Medical UNPENDED AMENDED 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the 3 Ectopic pregnancy 2 Fetal death Month Year past 12 months? Pregnant at time of death Box (5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 占 23e. Did tobacco use contribute to the cause of death? signed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ۵ 1 Yes 2 No 3 Probably 4 V Unknown ۵. Completed ficate has been si page 2 should b Records, 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medica ector, Division of Vital Be Hospital: 1 / Inpatient Other₄ Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA this 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 28d. Describe how injury occurred Manner of Death 28b. Time of Injury 1 V Natural 5 Pending 1 Yes 2 No after death. Director: the Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide within 24 hours a To the Funeral L determined Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 11, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 32. Registrar's Signature State Registrar

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		_	For State Registrar		laryland / Dep Ce	artment of H		R	eg. N 2010	22312		
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	Examin	er	4a. Facility Name (if not institution, given Upper Chesapea		anl Ctm							
	Funeral		5. Social Security Number 6.	Sex 7. Ac	ge (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth				
	Director		413-52-2853 Usual Residence of Decedent	I ⊠ M 2 □ F	74 Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 31,	Year) Co	ountry)		
	Maryland :8a-f shov tified at	rector	10a. State 10b. County Harf	ord	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🌠 No		
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 1000 Rockspri	1000 D 1 1 D 1								
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The strand Mental Hygiene. The strange of the than "thatural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.	No		2. Date of Death Seg. N. 20 0 223 2 2 3 2 3 2 3 2 3 2 3 2 3 2 3 3					
Maryland 21215-0036	within 72 hou giene. her than "nath t, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hut Fitter							•		
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Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 Other (Spec	ify)	Garde	matory or other place Memoria	2010	7 21,	Bel Air, N	/aryland		
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	Medical Examiner		resulting in death) Due to (or as a consequence of): Acidosis									
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~	to the propriat or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	☐ Ectopic pregnancy☐ Other (specify)	,			•		
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Vita	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ X No	Hospital:	ient 2 🗆 ER/Outpatie	Loui			nce 6 Other (Spec	cify)		
Division of Vital Records, P.O.	ath. r: After th	icate:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident ☐ Investigatio	28a. Date of inju (Month, Da	ury 28b. Time o	28c. Injury at 28d. Describe how injury occurred work?						
Divisi	rs after de al Directo ed in by th	Medical Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	28e. Place of Inj	ury - At home, farm, st c. (Specify)	reet, factory, office	2			ıral Route Number,		
1	to the rospital or Autenang Prysician: The lawithin 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page.		(Check 2 ☐ Medical Exan only one) 3 ☐ Certifying Nu	iner: On the basis of e	examination and/or inves	stigation, in my opinion	n, death occurred at t	the time, date and	d place, and due to the	cause(s) and manner stated.		
	Vith Con		29b. Signature and title of certifier	M				29				
	5		30. Name and address of person who Christa Fis	•			se Dr	Bel Ni∽	MD 21014			
	Stat	<u>-</u>	31. Date filed (Month, Day, Year)		ar's Signature	,	DI.,	DOLALL	_ FD 2 10 14			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ برارا 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crownsville 1151 Sevenwiew Drive Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F **Director** 216-38-3810 70 11-3-1939 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Crownsville 1 Yes 2 X No MD Anne Arundel 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ò "natural", or items 23a o Funeral 21032 1151 Sevenview Drive USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. ð 1 Never Married 2 X Married Yes 2**X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Caucasian 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales and Marketing Crystal Cote Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacob Lerov Dillon Sr. Pearl Ward permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Dillon/Wife 1151 Severniew drive, Crownsville, MD 21032 other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) injury or 7-20-2010 Eldersburg, MD Lakeview Memorial Gds. 21. Si. n. ture of Funeral Service Licer 22. Name and Address of Facility Wlie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a Parl 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, whock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year signed by the a d be detached for 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of nas autopsy page death? certificate h Yes 25. Was case referred to medical examiner? Division of Vital funeral director, æ 26. Place of Death (Check only one) Hospital: 22 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA MOSPILL မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗀 Homicide determined City or Town, State) within 24 hours a To the Funeral E Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DU064379 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

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32. Registra s Signature

Red Sate 300 Annaple MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Marylan		artment <i>tificate</i>			and Me	ental Hyg	jiene Reg. No 2 (010	22314
	Physicia		1. Decedent's Name (First, Middle, Last) Lemanuel Arthur Doame, Jr.						2. Date of Dear	th	Year	3. Time of Death 11:35P M
	Medic Examin	al .	4a. Facility Name (if not institution, give street and number)		4b. City, To	own, or l	_ocation o				inty of Death	TI:33E M
	LX		3901 Hannon Court Unit C				nghai					lto.
	Funeral Dírector		5. Social Security Number 6. Sex 1	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day)	Year)	g. Birthr Rh&de	place (State or Foreign E ^{ry)} Island
	>	- h	Usual Residence of Decedent	y, Town or Lo	cation							I Od. Inside City Limits
	farylan Ba-f sh tified a	ecto	Md. Balto.		ngham							1 🗆 Yes 2 💆 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 3901 Hannon Court Unit C		10f. Zip (212	236			10g. Citizen	of What Cour	ntry?
	death w items ?		11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Vas Decede f Yes, specif	nt of His	panic Orig	in? (Speci , Puerto Ri	fy Yes or No- ican, etc.)		Race - Americ	
336	s after c al", or Examin	d by	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced Armed Forces? 1 🛣 Yes 2 ☐ No If Yes, Give Year or Dates. 1941-		Yes 2						cify: Whi	
5-0	2 hours	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual kind of work	done du		of working	,	16b. Kind o	of Business Inc	dustry
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ore,	je 1 an t of He If item or othe		20a. Method of Disposition 20b. F 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispo emetery, cren	sition (Name natory or oth	of er place)	Da	- 1		on - City or To	own, State
Iţi	artmen artmen ortant: injury	-	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	view 22	2. Name and	Address				Balto.		
Ва	Deportant Permanent Perman		But a Well	Ŋ.	9705	Be1a	ir R	oad	imunek Notti	ngham,	Md. 2	21236
	Ph __ sician/		23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	h. Do not ente	er the mode	of dying	, such as o	cardiac or	respiratory arre	est,		Approximate Interval Between Inset and
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M.D.	be executed sician and burial-transi	dical Ex	that initiated events resulting in death) Last C. Due to (or as a consequence of the co	uence of):								
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Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	al death 3 [Ectopic po		/				Date of deliv Month	rery Day Year
P.O. I	that the ned by the detach		9 Unknown Part II. Other significant conditions contributing to death but not res	sulting in the u	anderlying ca	use give	en in Part I	l.	100			he cause of death?
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Division of Vital Records,	ling Physi). After this c funeral din	ate: To	27. Manner of Death 1 Natural 5 Pending 1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury		c. Injury work?	at □ Nu	28	ne 5 Resid 8d. Describe h			<u> </u>
ivisior	or Attencatter death	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At he bullding, etc. (Specification of the bullding) and could not be suited in the suited of the bullding.				res z 🗆	_	8f. Location (S City or Tow		mber or Rura	l Route Number,
۵	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier (Check only one) 3 ☐ Certifying Physician: To the best of my know only one) 3 ☐ Certifying Nurse Practioner: To the best of m	n and/or inves	tigation, in m	y opinio	n, death oc	curred at t	he time, date a	nd place, and	d due to the ca	ause(s) and manner stated.
	To the within to the comp	2	29b. Signature and title of certifier Deese Molinary M	ed			number 7 / 4	14			gned (Month,	
	1541		30. Name and address of person who completed cause of death (Iter	n 23a) (Type, I	Fal G	RI	Sait	20c	1001	morni	1/2 il	(B) 2008
	Star Registra		31. Date filed (Month, Day, Year) JUL 19 2010 Seneral 5. 4	ture		1 1	<u>-u1-</u>		/	. ((41)		

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			For State Registrar	State	of Maryla	and / Depa	artmen tificate			and M		giene Reg. N 2 (010	22315	
17	Physici	an.	Decedent's Name (First, Middle Control of the	_	Delahay Jul						Year	3. Time of Death			
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	Examin	The Johns Hopkins Hospital						nore			<u> </u>		N/A		
	Funeral Director		5. Social Security Number 236-82-0339	6. Sex 1 \square M 2 X_F	7. Age (In)	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth	1952	9. Birth	place (State or Foreign try) VIRGINIA	
			Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation							10d. Inside City Limits	
	Maryka-f sho	ctor	VA AUGU	STAUNT	ON						1 ☐ Yes 2 ☐ No				
	with the a or 28 be noti	Director	10e. Street and Number 307 GLEN AVENT		10f. Zip-	Code 24401	1				0g. Citizen of What Country?				
	death	Funeral	11. Marital Status	12. Was D	ecedent Ever in Forces?	1 U.S. 13.			*	gin? (Spec	cify Yes or No- lican, etc.)		Race - Americ		
36	rs after I", or ite caminer	by Fu	1 ☐ Never Married 2X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 Ye	s 2 X No Give Dates:		1 ☐ Yes 2		Specify:	i, ruento r	ilican, etc.)		Black, White, ec <i>ity:</i> W F	HITE	
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nd	be filed tal Hyg d other event, t	Be	17. Father's Name (First, Middle, CECIL ALBERT E			•					(First, Middle,	Maiden Suri	name)		
ıryla	should nd Men marke matic	욘	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address	(Street a			HELMS I Route Number	er, City or Tov	vn, State, Zip	Code)	
, Ma	and 2 sealth ar		J. RICHARD DEL	AHAY/HUS					STA		N, VA				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			b. Place of Dispo HORNROSE			9)		o/2010		TON, V		
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service	es this	101139	_ 85	2. Name an 2.1 LC	OCH F	RAVEN	BLVI	O. TOW	SON,		HOME, P.A. 1286	
	4.		23a Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final			140		e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Du	to (or as a con	vt failu sequence of):	he						-		
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Box	hat the death certificated by the attending placed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Liv	outcome of pre e birth 2 🗌 I	etal death 3	Ectopic p		/				Date of deliv Month	ery Day Year	
P.O.	the dea y the al ached 1	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ordeath 5	death 5 ☐ Other (specify)esulting in the underlying cause given in Part I.										
ds, P.	signe d be	by	Part II. Other significant condition	resulting in the u				23e. Did to	17		he cause of death?				
Division of Vital Records,	ne law requ has been ge 2 shou	Completed				•					24a. Was a autop	sy med?	prior to co death?	opsy findings available ompletion of cause of	
		Be Co	25. Was case referred to medical					·	26. Place	of Death	1 X Yes (Check only or	2 No ne)	1 Yes	2 🗆 No	
of <	Physician: this certifica ral director,	၉	examiner? 1 Yes 2 No 27. Manner of Death		Inpatient 2	2 ER/Outpatien		Othe 8c. Injury	4 🗀 Nu		ne 5 🗆 Resid			y)	
<u>o</u>	nding F ath. : After ie funer	ation	Natural 5 Pendir investi	g (M	onth, Day Year)	Injury	M	Work			ou. Doddilbe i	ow injury oo	burrou		
Divis	or Atter	Certification:	3 Suicide 6 Could 4 Homicide determ	inod 200. Fid	ce of injury - A Iding, etc. (Spe	t home, farm, streecify)	eet, factory,	, office		2	8f. Location (8 City or Tow		ımber or Rur	al Route Number,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical C		ng Physician: To t Examiner: On the											
	To the within To the comple	Me	29b. Signature and title of certifie	1 - 7			29c.	. License	number		:	29d. Date sig			
			P VVV	J	10	//tam 00c\ /T ::		SEZ	000			7/1	5/20	10	
				ttenb	vrg,	MO				600 N	lorth Wo	lfe St, E	Baltimo	re, MD, 21287	
	Sta Registr		31. Date filed (Month, Day, Year)	2010	Registrar's Sig	gnature 4	ales	9							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Roland Elwood Davis 10:30 AM 2010 July 14, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore #1 MacIntosh Court Apt J Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 17,1926 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days 1X M 2 □ F 219-10-7531 83 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21228 #1 MacIntosh Court Apt J 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 K Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🔀 No 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Architect 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roland Emery Davis Anna Elnora Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Davis Daughter 632 Apt B Harborside Apartments; Joppatown, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Atlantic Crematory 7/16/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) MOIOSO Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee MD 21228 1630 Edmondson Avenue: Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mediat Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

show

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite

traumatic event,

other 1

Department of Important; If Its any injury or o

permit.

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

burial-trai

Examine attending physician I for use as the buria Physician/Medical ed by the a detached t page 2 should be Completed

Be

2

Certification:

Medical

autopsy performe 1∐ Yes 2. [No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2⊠ No

25. Was case referred to medical examiner? 1 ☐ Yes R No 27. Manner of Death

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

Hospital:

28b. Time of

2 ER/Outpatient 3 DOA

Other: 4 \(\to\) Nursing Home 5 \(\tilde{\mathbb{N}}\) Residence 6 \(\tilde{\operator}\) Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Matural

2 Accident

3 ☐ Suicide

4 Homicide

1 Countrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

npleted cause of death (Item 23a) (Type, Print) 405

32. Registrar's Signature Date filed (Month, Day

State Registrar

DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

To the Hospital or A within 24 hours after or To the Funeral Direction

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JWIT V 15^{ay} 20 Y 0 Israel Deutsch 3:00 P M Ira Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10301 Grosvenor Place, #409 Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day August 23 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours New York 068-14-7290 Director 91 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits 1 Tes 2 X No Rockville Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 10301 Grosvenor Place, #409 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

Yes 2 No Black, White, etc ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify 3 Widowed 4 Divorced Completed WWII permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Federal Government / life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Scientist Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Max Deutsch Rosie Rosenheck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 19a. Informant's Name/Relationship (Type, Print) Dorothy K. Deutsch / Wife 10301 Grosvenor Place, #409, Rockville, Maryland 20a. Method of Disposition
1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Date 17, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Ju1y Montgomery Crematorium, Inc. Bethesda, Maryland 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. Barne M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Five Days Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or imjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year the 9 Unknown g Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stroke 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗆 Yes 2 🗶 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pendina Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier ٌ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) D37975 July 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20+1 Jeffrey Indrisano, M.D. 6410 Rockledge Drive, Ste. 401, Bethesda, Maryland 20817

DHMH 17 Rev 7/2009

State

Registrar

Day, Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Easley Ernest 2010 25 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Seasons Hospice 5. Social Security **5808** 212–32–5805 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Jaffonth 169, Year 935 Mary Land 74 Director Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MDBaltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 1720 Riggs Avenue 21217 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items? any injury or other traumatic event; the Natural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 😿 Yes 2 □ No If Yes, Give Year or Dates. Peacetime 1 ☐ Yes 2 X No Specify: B1ack Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) State of Maryland Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Robert Easley, Edna Mae Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1720 Riggs Ave., Baltimore, MD 21217 Barbara A. Easley (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 7/16/2010 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final prostate cancer Physician/ Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ☑ N 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 🗆 No 4 - Nursing Home 5 - Residence 6 Mother Specifical hospice 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completed filled in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 00057465 ns Rajapahrem.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S RajapaKSP M D 2835 M M Av. J-235 - Baltimore, MD. 21209

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 12:01 P.M. Albert Earl Eybs JULY 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ROSEDALE BALTIMORE FRANKLIN SQUARE HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) 1**⊠** M 2□ F Min Days Hours 220-22-2344 81 5-31-1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 □Yes 2KINo Baltimore Co. Essex 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 809 N. Woodward Drive 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 ∑Yes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Married 2 M Married 1 □Yes 2 X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) 12 College (1-4or 5+) Police Department N/A Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Johannah Bierman Albert E. Eybs 19a. Informant's Name/Relationship (Type. Print Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred E. Mullaney, Jr. 7511 Gilley Terrace Baltimore, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cem. 7-22-2010 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Lice 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISSEMINATED INTRAVASCULAR CCAGULOPATAL Due to (or as a consequence of): MALIGNANCY ABDOMINAL Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ENAL 2 No 3 Probably 4 Unknown 1 🗌 Yes

Physician /Medical Examiner

physician a s the burial-t

the attending plant hed for use as the

signed by the a

has page 2

certificate

this

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

After th funeral

à

Completed

Be

Certification: To

Medical

Physician

Examiner

Funeral

Director

works

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Maricel Evernine roust be notified at once.

Maryland 21215-0036

Baltimoré,

P.O. Box 68760,

Records,

Division of Vital

To the Hospital or Attending Physician:

after death.

/Medical

Director

Funeral

2

Completed

Be

MD

Examine Physician/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

VOCARDIAL

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

autopsy performed? Yes 2200 1 ☐ Yes 26. Place of Death (Check only one)

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 21237 STUART R. WILLES MD.

136663

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 19 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State Registrar	of Maryland / Depart <i>Certi</i>	ificate of		wentar riy	•	Reg. No.	2011	0 2232
Physicia ical Examí		Decedent's Name (First, Middle,Las Michael	Herbert	F	ear	1	2. Date of Dea Month July 8, 20	ath Day	Year	3. Time of Death
		4a. Facility Name (if not institution, give 616 North Decker Avenue		41	o. City, Town, or Lo	ocation of Death	July 0, 20		c. County of Deat	Rh
Funeral Director		5. Social Security Number 6. Se	x 7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Bi	,	1-	rthplace (State or
r any		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Locatio	n					10d. Inside City Limit
th the Maryland 23a or 28a-f show notified at once.	Director	MD 10e. Street and Number		imore	10f. Zip Code		1	•	zen of What Cou	1 X Yes 2 No
h with the ems 23a or	Funeral Di	616 North Decker 11. Marital Status 1 X Never Married 2 Married	Avenue 12. Was Decedent Ever in U.S. Armed Forces?	13. Was	21205 Decedent of Hispa s, specify Cuban, M	inic Origin? (Spe	cify Yes or No	US •-		rican Indian, 8lack,
s after deat ral", or it	۵		1 Yes 2 X No If Yes, Give Year or Dates:	1 \	fes 2 X No	specify:			Specify: W	hite
Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 5+	during mos	s Usual Occupation st of working life. D gammer				Kind of Business,	
d 2 should be filed within 7 Ith and Mental Hygiene. n 27 is marked other than umatic event, the <u>Medica</u>	Be Con	17. Father's Name (First, Middle, Last) Herbert	Fear			Mother's Name (Catherin		Maiden	Surname) Edwar	ds
d 2 should Ith and Me n 27 is man	٩	19a. Informant's Name/Relationship (Ty Mary E. Bistrick	(Aunt)	432 Sh	Address (Street a	., Linth		MD 2	21090	
permit. Pages I and 2 s Department of Health as Important: If item 27 injury or other traums		20a. Method of Disposition 1 X Surial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State cre	matory or othe	on (Name of ceme r place) k Cemete:		Date /10		Location - City on	Town, State Maryland
permit. Pages l and Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licens 23a. Part Enter the disease, or compl		36	me and Address of 20 Wilker	ns Ave.,	Balti:	more	e, MD 21	
/Medical xaminer transit	I Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
he death certificate be executed the attending physician and hed for use as the burial - transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month								y Day Year
signed by	à	Part II. Other significant conditions	contributing to death but not resu	ulting in the und	derlying cause give	en in Part I.		_		the cause of death?
The law requicate has been page 2 should	Completed						1 🗸 Yes	sy rmed?	prior to death?	utopsy findings available completion of cause of es 2 No
ling Physician: After this certifuneral director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28	∜Outpatient 3	3 DOA Oth		Home 5		nce 6 🗸 Other	
or Attenative death	Certification	1 Natural 5 Pending 2 X Accident Investigation 3 Suicide 6 Could not be determined	(Month, Day, Year) 7-8-10 28e Place of Injury - At home	11:40 e, farm, street,	to hot environment reet, factory, office building, etc. 1 Yes 2 x No to hot environment or For Town, State) 616 N.					ral Route Number, City
To the Hospital within 24 hours a To the Funeral completely filled	Medical Ce	one) 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/	death occurred		and place, and du	ue to the caus	e(s) and		ed
To Period		29b. Signature and title of certifier Thomas M,	Hand manner stated.	.)	29c, License n				9, 2010	nth, Day, Year)
		30. Name and address of person who co Theodore M. King, Jr., MD.		•	11 Penn Stree	t, Baltimore,	MD 21201	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22321 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of D Time of Death Physician/ onth DORP Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death nda 5. Social Security Number 8. Date of Birth (Month, Day,) Mar 20 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 XM 2 □ F 247-48-1207 Yrs **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA BALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1027 CATHEDRAL ST. 21201 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 2 X No Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: BLACK 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>óth</u> AUTO MECHANIC SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BROOKS FOUNTAIN BESSIE COYT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Fountain Bond-Daugn. Rollwin Road Baltimore MD 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date king Memorial Park 07/23/10 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Randallstown, 4 Donation 5 Other (Specify) 21. Si of Funeral Service Licenses 22. Name and Address of Facility 4300 Wabash Ave. Balto. MD 21215 March Funeral Home West, Inc. Balto. 23a. Part 1. Enter the disea shock, or heart failure. ease, or complications that caused, he death. Do not enter the mode of dying, such as cardiac or respiratory arrest p. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or ilinjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be et 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 🗌 No Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: 4 Nursing Home 5 Residence 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License numbe 29d. Date signed 30. Name and address of person who completed cause of death (Item 23a) (Type

Registrar

State

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22322 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ lannie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foldigm Country) **Funeral** 214-20-1 Director CAROLINA iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location hours after death with the Maryland Director BALTIMORE MD 1 Yes 2 🗆 No 10e. Street and Number 10g. Citizen of What Country? Funeral DUKE LAND 21216 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 Yes 2. No Specify. Specify: BLACK Completed 3 XWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric / WORK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) W. BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21216 ANDRE BALTIMORE MARY/And STREET Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2010 BALTIMORE, MARY/And Cemetery 4 ☐ Donation 5 ☐ Other (Specify) DERRICK C. JONES FH, P.A. 21. Signature of Funeral Service License 22. Name and Address f Facility BAltIMORE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final aspiration Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Be Completed by Physician/Medical spital or Attending Physician: The law requires that the death certificate be-iours after death.

Heral Director: After this certificate has been signed by the attending physicis iffled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year 1 ☐ Yes 2 ₩ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Previous CVA 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 잍 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 00616 on who completed cause of death (Item 23a) (Type, Print) and address of per

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) of Death Physician/ ever 45 M Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death andalltown 4105 DIC Limone If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | (Month, Day Social Security Number 6, Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-30-358 1 M 2 D F **Director** Yrs Usual Residence of Decedent 28a-f show 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Belverdene 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 BLack 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bald Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be REDRICK Race 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Department of Health a Important: If item 27 is any injury or other trans 50 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) on 21. Signa are A uneral Service Lice see Milees 22. Name and Address of Facility Part 1. Enter the dises se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph, sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ō Month Day Year page 2 should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 Director: After this certificate filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 5 Pending Natural 1 Tes 2 No Investigation Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my orbits, death occurred at the time, date and place, and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier . Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type,

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 22324 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 3 32 Leslie Ann Gray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITal Center Rosedale Ballimore FRANKLIN SQUARE Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖔 F Months Hours Min. (Month Par Year) **Director** 218-56-2275 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No MD n/a Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4411 Parkmount Avenue 21206 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 ☐ Married þ 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: African-American Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Harbor Court Hotel Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lawrence Gray Annie Jenny Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7116 Neville Court, Windsor Mill., ND 21244 Annie Jenny Gray/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 7-19-2010 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Par 12 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day the Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DVETILL CHILL 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 2 12 No __ Yes 25. Was case referred t edical Be 26. Place of Death (Check only one) in 24 hours after deaun.

The Funeral Director: After this of a projected filled in by the funeral director. 1 ☐ Yes 2 ☑ No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hou

To the Fune

completed fi

> State Registrar

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29b. Signature and the of certifier

30. Name and address of pa

Derwik

31. Date filed (Month, Day, Year)
JUL 19 2010

Certifying Nurse Fractioner T: the

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son who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

FRANKLIN Square DR

29d. Date signed (Month, Day, Year)

Balto md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Evelyn** D. Gaymon Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glan Burnie AnneArund Boltimore Washington Med If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, (Month, Day, Year, 5-25-1 1 □ M 2√2 F 58 Director 220-56-1729 952 Usual Residence of Decedent Gaymon, Delore's Baltimore, Maryland 21215-0036 or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Tes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7883 Crilley Road 21060 S Α 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: Black 3XXWidowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City ntary/Seconday (0-12) College (1-4 or 5+) 12th grade Special Aid Teacher Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Luke Artist Jessie May Everrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Venable-Daughter 7874 Americana Cir Burnie, MD 21060 Glen, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenmount 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial XXCremation 3 Removal from State 7-15-2010 Balto, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service License 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate terval Bet Immediate Cause (Final SEDSIS -Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner DNOUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): HIU/AIRS the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 1 ☐ Yes ∠¬∟ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Director: After this certificate 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation within 24 hours after dear To the Funeral Director completed filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year) 00022483 13, 2010 100 completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Name and address of persor

31. Date filed (Month, Day, Year)

COBS

Vospital Dr.

Glen Burnue, MD 2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** a.M. 2010 Doris Gerber /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Utmore Year | If Under 24 Hrs. Healt N/A 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year Funeral Months Days Hours 1 □ M 2 💢 F 90 214-14-0757 Yrs. 1920 Maryland Feb. 6, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show the Medical Exercises must be notified at 1 ☐ Yes 🌡 ☐ No Director MD Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3324 Washington Blvd. 21227 United States 23a Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: White 2 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, I'm Modie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Restuarant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Burker Edna Deal ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Anderson - POA 1725 Wilson Avenue, Baltimore, MD 21227 20b. Place of Disposition (Name of cometery, crematory or other place)
Meadowridge
Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 7-16-2010 Elkridge, MD 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. f Fun val Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia 12 haves /Medical Due to (or as a consequence of): 24 hours Examiner Dehydrato m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a configuence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a 1 □Yes 2 **2**No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 2 No 2 asten 1 ☐ Yes Covenary of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 □ No Medical Certification: To 14 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO064963 MI) 2010 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 900 South Conton Checkley Avenue 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 22327 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2010 Dorothy Irma Gustafson $J_{\mathbf{u}}^{\mathsf{Month}}$ 12, 5:00 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Halethorpe 4117 Old Washington Blvd. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Nov. 23, 1920 Months Days Hours 89 Director Maryland 217-09-4732 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Halethorpe 1 Yes 2 No MDBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 4117 Old Washington Blvd. United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Hodges Cora Lewis Petty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 21227 Old Washington Blvd., Halethorpe, MD 21227 Brenda Wagner - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery frematory groth Memorial Park 2 Cremation 3 Removal from Stat Other (Specify) 7-17-2010 Elkridge, MD Ambrose Funeral Home, Inc. of Fûneral Se 22. Name and Address of Facility 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death g Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 certificate ha irector, page 2 performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: ည 1 🗀 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🛮 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pendina nours after death. neral Director: Aft filled in by the fur 1 Yes 2 No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7-16 Maide Chaice Lune

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

19

2010

32. Registrarls Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep 1 - State Registrar Ce	artment of Health and M rtificate of Death	lental Hygier Reg. I	2010 22328					
Ė	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2 Date of Death	Day 16 Year 0 09:25 M					
. 4	Medic	al	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
(Examin		MERCY HOSPITAL	BALTIMORE	=						
	Funeral Director		5. Social Security Number 6. Sex 1 🖾 M 2 🗆 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Pay, Yea Sept • 19, 19	9. Birthplace (State or Foreign Country) New Hampshire					
	and show 1 at	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits					
	with the Maryis 23a or 28a-f ist be notified	Director	Maryland Baltimore Essex	Let 71 0 1		1 ☐ Yes 2¾ No					
		Funeral [10e. Street and Number 511 N. Woodward Dr.	10f. Zip Code 21 221	10g.	Citizen of What Country? USA					
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The stand Mental Hygiene. The stand of the than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
Baltimore, Maryland 21215-0036	thin 72 hou sne. than "natu ne Medica	Completed	(Specify only highest grade completed) (Give life. I Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation Lkind of work done during most of worki DO NOT use retired) Chanical Technicia	ing	Aerospace					
ر 2	illed wil Il Hygie I other vent, tt	a	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maide						
ylar	uld be f I Menta narked natic e	잍	Emily Guay	Laura Per							
Mai	12 sho alth and 27 is r ir traun			ing Address (Street and Number or Rura . Woodward Dr. Bal							
more,	Page 1 and nent of Hea ant: If item iry or othe		20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place) 1 Mem. Gardens 7/22		Location - City or Town, State altimore, Maryland					
Balt	1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Ma										
			23a Part 1. Enter the disease, or complications that caused the death. Do not en hock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arrest,	Approximate Interval Between Onset and Death					
	mysician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	PREUMONITIS							
-4:	Examiner	er	Sequentially list ponditions, b. CHLONIC 635	RUCTIVE RUMANARY	DISEASE						
8	uted d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events								
-	ate be executed bhysician and the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of):								
3760	ficate to g physi as the b	Medic	d								
Box 687	e death certificate be executed the attending physician and ched for use as the burial-transi	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year					
ds, P.O.	Physician: The law requires that the dea this certificate has been signed by the a ral director, page 2 should be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?					
Division of Vital Records,	rsician: The law require s certificate has been si lirector, page 2 should I	Completed by			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No					
/ital	sician: certific	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ patient 2 ☐ ER/Outpatient	26. Place of Death (Check		e 6 Other (Specify)					
on of \	nding Phys ath. r: After this ie funeral dii	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time (Month, Day, Year)		28d. Describe how in						
ivisi	or Afte after de Directo	Certil	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)					
Δ .	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge	stigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the cause(s) and manner states					
	To th Withir COMP	-	29b. Signature and title of certifier /	29c, License number	29d.	Date signed (Month, Day, Year)					
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, CHRISTOPMER KOLTZ	Print) 22 South Greenes	t 211	MCAR MA 212A)					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	s see tri obacie	· · · · · · · · · · · · · · · · · · · ·	more parts of the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death J_{ul}^{Month} Physician/ Rochard Juseph Green 08:26 2010 Medical 4a. Facility Name (if not institution, give street and number)
Hohcrely hencyal Honortal 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 🗆 F Min. 09-25-17957 215-70-2602 52 MD **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1025 Saddleback Way 21014 USA ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry 2 should be filed within 72 m th and Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/President Appliance Instillation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Monroe C. Green Rosemarie F. Bouchard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Deborah L. Green (Wife) 1025 Saddleback Way Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Bel Air Mem. Gar. 1 X Burial 2 Cremation 3 Removal from State 07-19-2010 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Signature of Funeral Sen Inc 610 W. MacPhail Rd Bel Air, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (oronay Medical resulting in death) Due to (or as a consequence of) Examiner disingl VALVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this course. Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 L retail Social
Pregnant at time of death
Unknown in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Tobacco use 1 Stres 2 □ No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 7/2009 29b. Signature

Kiemanh

pham

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clerent 32. Regin

DO069427

MD

15 2010

21044

DHMH 17 Rev 7/2009

Box 68760

P.O.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#26perPHYS, G905, 7/19/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar 22331 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JuIyPhysician/ CHARLES SHUOL 2 GLENN 2010 7:15 A Medical 4a. Facility Name (if not institution, give street and numbe Examiner 4b. City, Town, or Location of Death 4c. County of Death 448 Westfield Road Dundalk 8. Date of Birth (Month, Day, Year) Baltimore Co. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Min. 1 □XM 2 □ F Months Days Hours Country) New Jersey Director 214-58-5025 59 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Dunda1k 1 Yes 2XNo Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 448 Westfield Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ 1 Yes 2 2 1 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: "natural", Completed 3 Widowed 4 X Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Window Installer Construction 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jacqueline Gloria Orndorff Charles Francis Grosholz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2923 Shelley Ct. Abingdon, MD 21009 Shannon K. Grosholz(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗌 Removal from State ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7/15/2010 Towson, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Sinn ure of Funeral Service Licensee Dundalk. Maryland Wise Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final DISEASE Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ + IBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed PROBLEM S HYROID . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed SMORING. 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 12 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061413 12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9105 Fraudelin Sg Dr. # 299 Baltrue 21232 31. Date filed (Manth, Day, Year) State 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ d Medical Examiner 4b Birthplace (State or Foreign Country) 1 Year If Unde 24 Hrs 8. Date of Birth **Funeral** Month, Day, Year) 02-04-34 1 M 2 X X Days 76 MD 213-32-5288 Yrs **Director** 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XXYes 2 □ No MD NA Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Charles 524 N. Street Apt.#518 21201 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. African 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No ^{Specify:} American 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade NA Pius V Janitorial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph I. Plummer С. Duke Geneva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet C. <u> Wilkins-Niece</u> Baltimore. MD 21215 <u>Avenue</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Important: If it any injury or o 1 \(\bar{\text{N}}\) Burial 2 \(\Boxed{\text{Cremation}}\) Cremation 3 \(\Boxed{\text{Removal from State}}\) cemetery, crematory or other of New Cathedral Cem 07-20-10 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on sech line. Approximate Interval Betweer Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be 68760 IF FEMALE: fyes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death ed by the detached 9 Unknown P.O. signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of or Attending Physician: The law has autoosy perform 1 Yes 2 No 2 Z N of Vital director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 📝 No မှ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.
I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 \square Pending injury work?
1 Yes Division 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined within 24 hours af

To the Funeral Di

completed filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title 29d. Date signed (Month, Day, Year)

State Registrar who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22333 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Catherine Hoffmann AM July 2010 7:01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3 Dutrow Ct. Apt. 2D Rosedale Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 K F Months Hours Min. Nov. 27, 1936 Country) Marvland 216 32 6488 Director 73 Usual Residence of Decedent than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Rosedale 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Dutrow Ct. Apt. 21237 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Fink Catherine Elizabeth Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle M. Bishop (Daughter) 3923 Glenhurst Rd. Baltimore, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 7/22/2010 Bayview Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex. Maryland 21221 23a. Oat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 🔀 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 Yes 2 No Investigation 2 Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 10036951

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

State Registrar

Jeffrey Schluederberg M.D. 9114 Philadelphia Rd.Suite 108 Baltimore, Maryland 21237 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-05254 Kenneth Paul Haynes Physician/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 22334 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Month Day July 13, 2010 1450 hrs **Medical Examiner** Kenneth Pau1 Haynes 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Baltimore County** Halethorpe 5120 South Street B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 12/7/1963 Director 218-84-7459 46 Country) 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2X No Anne Arundel Pasadena MD s 23a or 28a-f show e notified at once. or 28a-f show permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 408 Alberta Avenue 21122 큠 uneral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married 2 X No Yes ū Yes, Give Year White 1 Yes 2 X No specify: Specify: 3 Widowed 4 Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical Forklift Company Parts Assoc. 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Edith Μ. Kuhn Wallace G. Haynes If item 27 is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 1010 Stewart Ln., Glen Burnie, MD 21060 Barbara A. Haynes (Wife) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory Baltimore, Maryland 7/16/10 @ Loudon Park Donation 5 Other Specify. 22. Name and Address of Facility Out on Park Funeral Home 21. Signature of Funeral Service Ligan 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Madical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical signed by the attending physician and be detached for use as the burial -UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ۾ 1 Yes 2 V No 3 Probably 4 Unknown σ. Completed Records, has been a 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? 2 this certificate Yes 2 No 1 Yes No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical of Vital 8 Hospital: 1 Other₄ examiner? Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 2 No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death After Subject shot self FOUND: Division Natural 1 Yes 2 ✓ No Pending neral Director: Jul 13, 2010 1431 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 2Be. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 5120 South Street, Halethorpe, MD determined (Specify) Woods To the Funeral Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medica Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of certifie 29b.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 32. Registrar's Signature State Registrar

Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

July 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3:25 ΑМ 13 July Mildred Epstein Hirsch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Nov. 30, Year) 915 1 ☐ M 2 😿 F Months Days Hours New York 94 **Director** 055-12-6518 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 20852 6111 Montrose Road U.S..A or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black White etc δ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" 3 X Widowed 4 Divorced Completed Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than * Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Yetta Hertz Herman Haber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8902 Miles St., Silver Spring, MD 20901 Eleanor Krasner (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ponation 5 Other (Specify) Mt. Pleasant Cemetery 7/16/10 Hawthorne, NY ture of Funeral Service Lic-22. Name and Address of Facility Hawthorne Funeral Home 21. Sign Hawthorne Stevens Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury Due to (or as a consequence of): the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. eral Director: After this certificate has been signed I filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Anpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation after death Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check rtifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tit 29d. Dat signed (Month, Day, Year) 7/13

Registrar

DHMH 17 Rev 7/2009

State

8600,01d Georgetown Rd., Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rohatgi, MD

31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

		•	For State Of Maryla State Of Maryla Registrar		tificate of D				eg. No.	010	22336	
	Physicia		1. Decedent's Name (First, Middle, Last) $Sarah Hil$	//			2.	Date of Death Month	Day	Year	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location o	of Death	_07	4c. C	2010 ounty of Death		
_	/ 		3208 BULL Hill Road 5. Social Security Number 6. Sex 7. Age (In yrs.	(act hirthday)	Gwy If Under 1 Year	ynn (Date of Birth		Baltin	nore pplace (State or Foreign	
	Funeral Director		242-30-4522 1 M 2 X F 90 Usual Residence of Decedent	Yrs.	Months Days	Hours		Month, Day.	Year) 20	Cou	ntry) NC	
	land show dat	tor	10a. State 10b. County 10c. C		10d. Inside City Limits							
	e Mary r 28a-1 notifie	Director	MD Baltimore C	Swynn (1 -Yes 2X No	
	with th	Funeral [3208 Blue Hill Road		10f. Zip Code 21 2	207		1	_	en of What Cou	intry?	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2X No	l.S. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Oriç n, Mexican	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14	I. Race - Amer Black, White		
21215-0036	ırs afte ural", c Il Exam	ted by	3 ★ Widowed 4 □ Divorced T □ Yes Calive Year or Dates.	1	I ☐ Yes 2 🗶 No	Specify:			Sp	pecify: B1	ack	
15-(72 hou n "natu Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done d O NOT use retired)		of working	(1)	16b. Kind	d of Business I	ndustry	
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Maryland	should b and Mer is mark raumatic		DeVester Paige 19a. Informant's Name/Relationship (Type, Print)	19b Mailir	ng Address (Street a			arrin	_		Code)	
Ĭ,	and 2 sh Health ar tem 27 is		Jeffrey Moore-Nephew		Pheasant				-			
Baltimore,	- 4 E 6		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Place of Dispo cemetery, crem Wood	natory or other place		Date 7/20/			ation - City or T		
Balti	permit. Page Department Important: II any injury or		21. Signature of Funeral Service Licenspe	M 4	Name and Address arch F/ 300 Wab	s of Facilit H We ash	st Ave,	Balti	mor	e, Md	21215	
			23a. Part 1. Enter the disease, or complications that seased the decease, or heart failure. List only one cause on each line.		er the mode of dying	g, such as	cardiac or re	spiratory arres	st,		Approximate Interval Between	
	Physician/ Medical	ì	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conse		tic co	ardio	Valcu	lur.	Ns e	ease	Onset and Death	
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19	cate be executed physician and the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consecutive	quence of):	<u>~</u>						year)	
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687	certifica nding p	n/Me	IF FEMALE: 23c. If yes, outcome of pregrant 23c. If yes, outcome of pregrant						23	d. Date of deli	verv	
P.O. Box 68760	ne death or the atter ched for u	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnancy Other (specify)	у				Month	Day Year	
s, P.0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I		23e. Did tob			the cause of death?	
örd	w requ is been 2 shoul	Completed by						24a. Was an		24b. Were auto	opsy findings available ompletion of cause of	
Red	sician: The law certificate has b lirector, page 2 s	Com						perform	ned? No	death?	2 No	
/ita	sician: certifi irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	7 50/0-1-1	Othe	ar.	th (Check on			Other (Specia		
n of \	ding Phy h. After this funeral d	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at	28d	. Describe how			у)	
Division of Vital Records,	or Atten after deat Director: in by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At I building, etc. (Special Could not be building, etc. (Special Could not be building).				_	Location (Str City or Town,		Number or Rura	al Route Number,	
Ω	Hospital 24 hours Funeral eted filled	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my known than the Medical Examiner: On the basis of examinating the Medical Examiner: On the basis of examinating the Medical Examiner.	on and/or invest	tigation, in my opinio	n, death oc	curred at the	time, date and	d place, a	nd due to the c	ause(s) and manner stated.	
	To the within To the compl	Σ	only one) 3 Certifying Nurse Practioner: To the best of r 29b. Signature and title of certifier	ny knowledge, c	29c. License	-	and place, a			signed (Month,		
)		Droggen Mr)		<u> </u>	328	77		Juli	13	2010	
	8		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, P	M) 5	40	0	010		COUN	own mb	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature & Car	es i							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. N2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July Physician/ Hook Alfred 2010 7:58 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Nursing Center 8. Date of Birth
(Month, Day, Year)
July 5,1940 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** XXM 2 □ F Months Hours Country) Germany 70 579-58-6089 Director Yrs Usual Residence of Decedent show 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director Dunda1k 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7409 St. Patricia Court 21222 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 п Yes, Give Year or Dates. Vietnam 1 Yes 2 X No Specify: Specify: 3 Widowed XX Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aviation 12 Years Mechanic Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Claire Kruse Lester Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33326 Weston, FL Jeanette Lawrence (Sister) 501 Birchwood Way permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/16/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicenses Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph sician/ LADDER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be execut that initiated events resulting in death) Last signed by the attending physician and a be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) #OSPICE 2 🔀 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ျ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation npleted filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) VÁ 064395

State Registrar 6701

32. Registrar's Signature

MARLES ST, SUITE 4105

BALTIMORE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN, MD

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 Certificate of Death 1. Decedent's Name (First, Midgle, Last) 2. Date of Death 3. Time of Death Physician/ 201U 0619 MOS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arundel 935 Fall Ridge Way Gambrills Anne 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 AM 2 | F Mary land Days 06/03/ Months Director 215-38-9329 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 X Yes 2 No MD Anne Arundel Gambrills Of. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral 23a 21054 935 Fall Ridge Way U.S.A. or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
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Yes 2 □ No Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Mechanical Technician Service Stations permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) ည Richard Iman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 935 Fall Ridge Way, Gambrills, MD 21054 Donald House / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 07/16/2010 Hanover, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry michael 7522 Connelley Dr., Ste. P, Hanover, MD 21076 margu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and eath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-transit Exam death certificate be execute that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 L Unknown 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death. • Funeral Director; After this certificate has been signed by th s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available 24a. Was an cate has b ; page 2 st prior to completion of cause of death? performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2. only one)

State Registrar Name and address of pe

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Maryland 21215-0036

Baltimore,

P.O. Box 68760

Records,

Division of Vital

DHMH 17 Rev 7/2009

eted cause of death (Item 23a) (Type,

32 Registrar's Signature

State Registrar DHMH 17 Rev 1/2001

OCME 2006

1/2

July 12, 2010

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Register's Signature

Zabiullah Ali, M.D.

O.C.M.E

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ ^D1 6 2010 July 6:22 Hatfield Doris Μ. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 139 Sullivan Rd. Westminster 8. Date of Birth Jan 19, 1923 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛛 F Months Mary and 87 Director 215-14-4964 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🗶 No Westminster Md. Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 "natural", or items 23a o Funeral USA 21157 139 Sullivan Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 permit, Page 1 and 2 should be filed Department of Health and Mental Hy, Important; if item 27 is marked oth, any injury or other traumatic event, once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Irene Sterling Fritz Metschulat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 Sullivan Rd. Westminster, Md. 21157 Mrs. Irene Catlin/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7-21-10 Baltimore, Md. Moreland Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service Cense 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHRONIC UBSTRUCTIVE PULMONARY Physician/ DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying signed by the attending physician and defached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CONGESTIVE HERRA FAILURE 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ANEMIA cate has page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 Yes 2 No 5 Pending injury Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 040480 July 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROMO 7602 0 FERNANDO 21236

State Registrar 32. Register's Signatus

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. NZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9VENC 7010 5:20 AM Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner timore timore ton 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M M 2 - F Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No more 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U 59 items . Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Completed by 1 Never Married 2 Married 2 No should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College/(1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) ural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number Page 1 and 2 Baltimore. 20a. Method of Disposition 20b. Plage of Disposition (Name of cernetery, crematory or other 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State any injury or 4 ☐ Donation 5 ☐ Other (Specify) Fyneral Services Sidnatu of Funeral Service Licensee 22. Name and Address of Facility Wohn au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions, If any leading to infriediate cause. Enter Underlying Cause (Disease or iinjury Due to forms a consecuence on the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 for use as IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month 2 🗌 No • o une runeral birector: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Physician: The law requires that the Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Stimul Pulsul rmed? 2 🔼 No ou Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 If Residence 6 Other (Specify) 2 🛍 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 🖺 Natural 5 🗆 Pending injury work? Division 2 🗌 No within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titl of death (Item 23a) (Type, Print) 30. Name and address of pe 400 MOG 32. Registrar's Signature State Registrar

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DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie Pe 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 15 2220 2010 July HAZEL В. KENLY-MURPHY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD MEMORIAL HOSPITAL HARFORD CO. HAVRE DE GRACE If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 200 85 Yrs. Director 217-20-9247 July 9 1925 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes ZXXNo Director MARYLAND HARFORD CO ABERDEEN 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 31 LIBERTY STREET 21001 Funeral U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 📉 🗸 Specify: Specify: BLACK Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10th grade HOUSEWIFE PRIVATE other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fil of Health and Mental H item 27 is marked oth ၉ GEORGE W. KENLY HATTIE J. KENLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other t Kathleen Mack/Daughter 1122 Gordon St. Extension, Greenville, S.C. 29611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its 1XXSurial 2 Cremation 3 Removal from State 4 Donation & Other (Specify) MT CALVARY CHRCH CEM 07-23-10 ABERDEEN. MARYLAND 21. Signature of Funeral State Can inch 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, Reduce 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 23a. Part 1. Epre the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Seven PSIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1 No Vital 1 Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \((Specify) \) 1 Yes 2 40 Certification: To ₹ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Division 1 CHIstural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) ţ, 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who correlated cause of death (Item 23a) (Type, Print) homas

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	for Amend Items State Registrar	State of Mary	and (Deco	tificate of L	201 Ouris d N Death	flental Hyg	giene 2 0	10 22343	3	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last					2. Date of Dea Month July	Day 17	3. Time of Death		
-	Medic Examin	al	Eliza Ann King 4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, o	r Location of Death	July	4c. County		Л	
'	LXaiiiii	ici	Figure Care Old Court				llston		,0,,,,	Baltimore		
	Funeral Director		217 34 4073	MODE	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl Month, Day 1-21-1	Year)	Birthplace (State or Foreigr Country)	n	
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Loc	cation				10d. Inside City Limits		
	//anyla //8a-fs tified	Director	Md n/a		Baltimo	re				1 🄀 Yes 2 □ No	lo	
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If then It han Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at.		10e. Street and Number	-		10f. Zip Code				of What Country?		
		Funeral	3800 W. Rogers Avenue			212		" V	US			
Maryland 21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?, 1 ☐ Yes 2 A No If Yes, Give Year or Dates.	If	vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	city Yes or No- Rican, etc.)	Blac	e - American Indian, ck, White, etc. African-American		
5-0	2 hour	plet	15. Decedent's Ed (Specify only highest grad		j (Give k		during most of worki	ng	16b. Kind of B	Business Industry		
121	rithin 7 iene. r than the M	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	I	O NOT use retired) ol Teacher			Balto Cit	ty Public Schools		
pu	filed w al Hyg d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name				П	
yla	uld be I Ment narker natic e	၉	Rudy Lee Crisp				Mary Fran					
, Mai	nd 2 should be file ealth and Mental I m 27 is marked o ier traumatic eve		19a. Informant's Name/Relationship (Type Regina M. Davis/ Dau		31.32 Ripple Road, Windsor Mil			I Route Number	; City or Town, S 244	State, Zip Code)		
Baltimore,	permit. Page 1 and a Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State A	11-	emorial	Park 07/2	Date 2/2010	Arbutus	ocation - City or Town, State		
Balt	permit. Departi Import any inji	Home P.A MD 21133	of Ralto. Co.									
			23a. Part 1. Enter the disease, or compleshork, or heart failure. List only on	cations that caused the ce cause on each line.	leath. Do not ente	r the mode of dyin	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between		
	Trysician/	i Y	Immediate Cause (Final disease or condition resulting in death)	A L2 H Due to (or as a cons	EIMER	-1 PE	MENT	A		Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):							
_		iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):							
8	cuted ind transit	Examin	Cause (Disease or linjury that initiated events	Due to (or as a cons								
^ _	ate be executed physician and the burial-transit		resulting in death) Last	. Due to (or as a cons	sequence oi).							
2	icate l	l edical		d								
Box 687	h certii tending r use a	an/N		3c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐	gnancy Fetal death 3 □	Ectopic pregnanc	су			ate of delivery	h	
. Bo	the deatly the attached fo	Physician/M	in the past 12 mopths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)			Mo	onth Day Year		
s, P.O.	r requires that the death certific been signed by the attending should be detached for use as	by	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.			ribute to the cause of death? 3 Probably 4 Onknown	/n	
ord	iw requasi beer 2 shou	Completed						24a. Was a		Were autopsy findings available prior to completion of cause of		
Rec	The la	Com							med?	death? 1 □ Yes 2 □ No		
ta	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:		Oth	ace of Death (Checker:				-	
οţ	g Physer this er this eral di	e: To	27. Manner of Death	28a. Date of injury	ER/Outpatien 28b. Time of	t 3 L DOA 28c. Injur	4 Nursing Ho		ence 6 L Other			
on	ending eath. or: Aftu the fun	ficat	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year) injury	M 1 □	Yes 2 No					
Division of Vital Records,	or Attend after death Director: A in by the f	Certificate:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre ec <i>ify)</i>	et, factory, office		28f. Location (S: City or Town		er or Rural Route Number,		
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 L Medical Examin		ation and/or investi	igation, in my opinio	on, death occurred at	the time, date ar	nd place, and due	e to the cause(s) and manner state	ted.	
	To the within to the To the Comple		only one) 3 ☐ Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of	n my knowleage, a	29c. License				d (Month, Day, Year)		
	7				и.р.		722		JULY 1	9 2010		
_	(30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type, Pi	rint) LENE TA	LEE RUAP	#300 (PILESVIL	LE MD 21208	<u> </u>	
	Stat Registra		31. Date filed (Manth, Day Year) 101 92010	32. Registrar's Si		del .						

Amend #1, per State of Maryland Department of Health and Mental Hygiene For State Registrar Reg. No. 20 22344 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 16, 2010 Year Physician/ Mildred Sallye Krieger M. Sallye Krieger 10:13 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore Broadmead Cockeysville . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Dec. 17) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2.XXF Months Hours Min. Maryland Director 220-24-6822 81 Yrs. 1928 Usual Residence of Decedent 1013 AP 10b. County 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at with the Maryland Director 1XXYes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatte event, the Medical Examiner must be roone. Funeral 6210 Park Heights Avenue, Apt. 600 21215 of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XX No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2XXMarried Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 10th Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 မ Louis Frank Loewner, Sr. Etta O. Oppenheim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 600 19a. Informant's Name/Relationship (Type, Print) Morton M. Krieger, M.D. (Husband) 6210 Park Heights Avenue, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of July 20, 20, 2010 20c. Location - City or Town, State G cemetery, crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State Baltimore Hebrew 4 ☐ Donation 5 ☐ Other (Specify) Reisterstown, Maryland 21. Signature of February Selvice Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Second Due to (or as a consequence of): Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence or, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregr 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown Month Year Day Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 nknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? ongestive 2 🔼 No 1 Tes 25. Was cas re rred to medical examiner (
1 ✓ Yes 2 ☐ No reral Director: After this certific filled in by the funeral director, Be Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident 5 Pending Tuylo, 2010 | [CO A M 1]

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Investigation 6 Could not be Suicide 28f. Location (Street and Number of Rural Route Number, Ave City or Town, State) (27) of Salk He (Shiffs #LOO (SG) Timore, Md 2(21/5) 4 Homicide determined ome 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier within 24 hou

To the Fune

completed file (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year) cause of death (Item 23a) (Type, Print) O 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 22345 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 16, 2010 0717 hrs Medical Examiner JASON ROBERT KUZNIARSKI 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** 523 S. Chester Street B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreian Months Hours Director 215-19-5739 1X M 2 F 28 08/12/1981 Country) MD Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location MD s 23a or 28a-f show a 1 X Yes 2 No BALTIMORE N/A Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 USA 523 S. CHESTER STREET Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, ral", or items 2 niner must be n 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than " restaurant 21215-0036 bartender 12TH marked other 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert H. Kuzniarski Valerie A. Curnutte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Valerie Kuzniarski / Mother Lark Meadow Ct.: Nottingham, MD 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery. 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Important: I 7/21/2010 Metro Crematory, Inc Catonsville, MD 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee The Johnson Funeral Home, P.A. MO0217 Loch Raven Blvd., Towson, MD 21286 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Hanging Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause se or injury that is Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed pur Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Month 1 Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown the ted f 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has brector, page 2 sh performed? death? page Yes 2 V No 25. Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Division of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 🗸 Other Scene DOA ER/Outpatient 3 this 1 Yes 28a. Date of Injury FOUND: After 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject hanged self within 24 hours after death.

To the Funeral Director: A completely filled in by the fur **FOUND**: Natural 1 Yes 2 ✔ No Pending Jul 16, 2010 0000 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 523 S. Chester Street , Baltimore, MD determined (Specify) Rowhouse 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 16, 2010 du 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

April 7, Hours 1 🛛 M 2 🗆 F T940 70 **Director** 212-38-2915 Usual Residence of Decedent shov 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Maryland Silver Spring Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1708 Sanford Road 20902 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institutes permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) of Health Biologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Violet L. Bowman Ralph Keister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lucinda H. Keister/Wife 1708 Sanford Road, Silver Spring, Maryland 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date July 18, 2010 Bethesda, Maryland Montgomery Crematorium 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Signature of Funeral Service License Milkan M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive Heart Failure Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-transit death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 2 No Yes 1 ☐ Yes ∠ L g ☐ Unknown Hospital or Attending Physician: The law requires that 24 hours after death. 8 Funeral Director: After this certificate has been signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 M Unknown Chronic Obstructive Pulmonary Disease page 2 should Waldenstrom Macroglobulinemia 24a. Was an DAVID autopsy perform Yes 2 No 25. Was case referred to medical examiner? Vital funeral director, 26. Place of Death (Check only one) B B Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗓 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 욘 EISTER, Division of . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

Date filed (Month, Day, Year,

9

1. Decedent's Name (First, Middle, Last)

Suburban Hospital

Social Security Number

David Bowman Keister

4a. Facility Name (if not institution, give street and number)

Physician/

Medical

Examiner

Funeral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

7. Age (In yrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene 0 | 0

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Bethesda

Reg. No.

15

. 2<u>010</u>

4c. County of Death

Montgomery

Black, White, etc.

Month

death?

Day

24b. Were autopsy findings available prior to completion of cause of

1 Yes 2 No

Year

20814

РМ

6:17

9. Birthplace (State or Foreign

White

10d. Inside City Limits

1 Yes 2 X No

20902

Approximate Interval Between Onset and Death

Michigan

2. Date of Death

July

8. Date of Birth

Registrar DHMH 17 Rev 7/2009

State

20

8600 Old Georgetown Road, Bethesda, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 8:30 PM JÜLY Catherine Kutson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birth (Month, Day June 13 g. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** Months 1 □ M 2 👿 F . 1<u>920</u> Hours Pennsylvania Director 90 June 213-12-4655 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 No Timonium Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a or edical Examiner must be Funeral 12261 Round Wood Road 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed 3 Widowed 4 Divorced White her than "natur t, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 듛 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Hondroulis Hajimihalis Steliane Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 12261 Round Wood Road, #1301 Important: If item 27 Timonium, Maryland Constantine N. Kutson Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dat 2010 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimore 4 Donation 5 Other (Specify) Greek Cemetery July 21 Signatur of Funct | Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ Pneum disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Due to for della consecutance of physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? cate has been signed by the atterpage 2 should be detached for a 4 Pregnant at time of death
9 Unknown Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pericardia (EFFUSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner?
1 Yes 2 No Other: 1 M Inpatient 2 ER/Outpatient 3 DOA ဂ္ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined To the Hospital Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hor To the Fune completed fi 10 State

SON

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

14th a

Cynthia

main

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30(19

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00051347

6701 N. Charles St Ralpmore 48 21204

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

BENJAMIN LAZARO

				Please	Type or Pri					-		_	
			For State Registrar		State of Ma	aryland	-	artment of F tificate of L	Health and N Death	Mental Hy	giene Reg. N	2010	22348
			Decedent's Name (First)	t, Middle, Last)	-					2. Date of De			3. Time of Death
and the	hysicia Medio		Benjamin		La	zaro	· <u>-</u>			Month 07	I D	2010	01:20 AM
<i>j</i>	Examir	er	4a. Facility Name (if not in					4b. City, Town, o	c. County of Dea	th			
F	uneral		Good Sam 5. Social Security Number	aritar 6. Sex	Hospit	al e (In yrs. las	st birthday)	If Under 1_Year	imore If Under 24 Hrs.	8. Date of Bi	rth	NA 9. Bii	thplace (State or Foreign
	irector		218-58-85	20	7. Age M 2 □ F	54	Yrs.	Months Days	Hours Min.	oc M	D (untry)		
pu	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location												10d. Inside City Limits
Vanyla	8a-fs tified	Director	MD	NA		В	altim	ore					X⊠ Yes 2 □ No
h the l	a or 2 be no	al Di	10e, Street and Number					10f. Zip Code	0		10g. C	itizen of What Co	ountry?
ath wit	ms 2%	Funeral	115 Meli		Venue 2. Was Decedent E	ver in II S	13 1	2121	Z Z ispanic Origin? (Spe	noify Von or No		USA	ada an Indian
6 er deg	or ite miner	by Fi	1 Never Married 2		Armed Forces?		l II	Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		14. Race - Ame Black, Whit	e, etc.
003 urs aff	tural", al Exa	ted	3 ☐ Widowed 4 🔼 D		If Yes, Give Year or Dates.		1	☐ Yes 2X No	Specify:			Specify: ${ m Fi}$	lipino
15-	State 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10c. Street and Number or Rural Route Number, City or Town, Street 10c. Street												Industry
212 within													oyed
and e filed	17. Father's Name (First, Middle, Last) Benijno R. Lazaro 18. Mother's Name (First, Middle, Maiden Sumame) Margret Gillard											,	
ould b	mark	-	19a. Informant's Name/Re				10b Mailin	a Addrona (Stroot	Margr and Number or Run				n Cadal
d2 sh	27 is er trau	j	Benijno I		, ,	1					_		4D 21237
ore, etan	If item or othe		20a. Method of Disposition	n		20b. Pla	sition (Name of	ocation - City or	Town, State				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	rtant: njuny o		4 Donation 5 D	Other (Specify)		Cremator Name and Address					le, MD		
Bal permi	lmpo any ir once		21. Signature of Funeral S	eral Ho Ltimore	ome P.A. e,MD 21217								
1													
	sician/ ledical												
Exa	miner		Sequentially list condition										Unknown
b `₽	ii.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events. Dus to (or as a consequence or). Poeumonia										
executed	ian and urial-transit		that initiated events resulting in death) Last	С	Due to (or as a								Unknown
8 epe	iysiciar ie buri	lical		La									
Box 68760 death certificate by	ling ph e as th	Mec	IF FEMALE:	00	c. If yes, outcome	of p							
OX (attend for us	cian	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No	anı	1 Live Birth 4 Pregnant at	2 🗀 Fetal	death 3 🗌	Ectopic pregnand Other (specify)	ÿ		1	23d. Date of de Month	livery Day Year
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S, P.O.	signed be de	Completed by Physician/Medical	Part II. Other significant of Diabetes n										the cause of death?
ords requii	should	lete	tion, Thro				010177	711.71.4.		24a. Was			topsy findings available
Zec	certificate has birector, page 2 s	omo;	110(1, 11)		y iopen					auto perfo	psy ormed? 2 M N	death?	completion of cause of
cian:	ertifica ector, p	Be	25. Was case referred to m exammer? 1 ☑ Yes 2 ☐ No	the second	espital:				ace of Death (Check	_	2 02 14	5	
of Vi	r this o	2	1 ☑ Yes 2 ☐ No 27. Manner of Death		1 Inpatie	y 2	R/Outpatient	28c. Injury	4 U Nursing Ho	me 5 Residence 1			eify)
on C anding ath.	r: Afte	licate	2 Accident	Pending Investigation	(Month, Day,	Year)	injury	work		EGG. BOSONBOT	iovi injui	y cocarred	
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	Directo in by t	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injuit building, etc.		e, farm, stre	et, factory, office		28f. Location (\$ City or Tox			ral Route Number,
Spital hours	d filled	Medical	29a. Certifier 1 Ce	ertifying Physic	ian: To the best of r	ny knowled	dge, death o	ccured at the time,	date and place, an	d due to the ca	use(s) ar	nd manner as sta	ated.
the He	the Fi		only one) 3 L Ce	ertifying Nurse	r: On the basis of ex Practioner: To the b	amination a best of my k	and/or investi knowledge, d	eath occurred at the	e time, date and plac	the time, date a e, and due to th	e cause(s) and manner as	
No.	6 8		29b. Signature and title of	DOL ME	NUCCI,	MD			RES-01			te signed (Mont) - /11 / 2	
	3		30. Name and address of p	person who con	npleted cause of de	eath (Item 2	3a) (Type, Pr	int) MAR	1A MEN 21239	vcci			
	Stat legistra	е	31. Date filed (Month, Day, JUL 19 201	Year)	32. Registra	r's Signatur	re			-			
	- Sionic		201	in per	and pa.	July Cl							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	ite of Maryland / Dep <i>Ce</i>	artment of Heartificate of De	-	giene Reg. N2010	22349
Physic		1. Decedent's Name (First, Middle, Last)	M	clain	2. Date of De Month		3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give street a The Johns Hopkins Hospit		4b. City, Town, or Local Baltimore C	·	4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex $1 \square M$ 2. $215-22-0414$	X F 7. Age (In yrs. last birthday)		Hours Min. 8. Date of Bir (Month, Date of Aug. 1	ay, Year) Cou	hplace (State or Foreign intry) YLAND
Maryland I-f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	BALTIMORE			10d. Inside City Limits XXYes 2 □ No
with the 3a or 28a	al Director	MARYLAND N/A 10e. Street and Number 516 WINSTON AVENUE	F	10f. Zip-Code 2121	2	10g. Citizen of What Cou	intry?
and 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. so other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral	11. Marital Status 12. Wa Arr 1 Never Married 2 Married 1	is Decedent Ever in U.S. ned Forces? Yes 244Wo les, Give	Was Decedent of Hispa If Yes, specify Cuban, M	anic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	14. Race - Amer Black, White	e, etc.
15-00% n 72 hours "natural", edical Exa	Completed by	15. Decedent's Education (Specify only highest grade comp	ar or Dates: 16a. Dece (Give	edent's Usual Occupation with the kind of work done during DO NOT use retired)	on ing most of working	16b. Kind of Business/	ACK Industry
ryland 212: hould be filed within d Mental Hygiene. marked other than matic event, the Me	Be Comp	Elementary/Secondary (0-12) 6th grade 17. Father's Name (First, Middle, Last)	lege (1-4 or 5+)	RDEEN PROVI	NG GROUND B. Mother's Name (First, Middle	GOVERNMEN e, Maiden Surname)	T
Maryland 21215-0036 at 2 should be filed within 72 hours aft th and Mental Pygiene. Its marked other than "natural", or traumatic event, the Medical Examir	5 B	CHARLES E. DORSEY 19a. Informant's Name/Relationship (Type. Prin	nt) . 19b. Mail		PAULINE M AKIN		ip Code)
		Monalisa E. McLaine/ 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remova	Daughter 516 20b. Place of Disp		enue, Baltimon	re, Maryland 20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any injury or other		4 Donation 5 Other (Specify) 21. Signature of Fune all Services in the see	BURKLEY	CEMETERY 2. Name and Address of WILLIAM C B	ROWN COMMUNITY	DARLINGTON, Y FUNERAL HO	
		23a. Pan 1. Enter the disease, or complications shock, or heart failure. List only one caust	that caused the death. Do not en	1206 W NOR ter the mode of dying, s		arrest,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	nemor	rnage		
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events c.	Oue to (or as a consequence of):				
x 68760, of certificate be executed ding physician and use as the burial-transit	dical Ex		Due to (or as a consequence of):				
box 64 death certific e attending p	Physician/Med	in the past 12 months?		Ectopic pregnancy Other (specity)		23d. Date of del Month	ivery Day Year
	by	Part II. Other significant conditions contributing	ng to death but not resulting in the	underlying cause given	in Part I. 23e. Did	tobacco use contribute to	j
Tec	Completed				24a. Was auto perfic	psy prior to open death?	topsy findings available completion of cause of
T VITAL I ysiclan: The s certificate I director, pag	To Be C	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) Hospita	I: 1 Herpatient 2 ☐ ER/Outpatie		6. Place of Death (Check only of 4 Nursing Home 5 Resi	one)	
DIVISION OT VITA or Attending Physician: after death. Director: After this certific. I in by the funeral director,		Natural 5 Pending investigation	Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 \(\triangle \text{Yes} \)	28d. Describe	how injury occurred	
5 ಕ# ਨੂੰ ⊆	Certification:	4 Homicide determined	Place of injury - At home, farm, st building, etc. (Specify) To the best of my knowledge, deat		City or To		
the the	Medical	(check only 2 Medical Examiner: Or	the basis of examination and/or in d manner stated.		ion, death occurred at the time		e to the cause(s)
To wit		Hattlene Thom 30, Name and address of person who complete	as MD	RES	-003-	July	6,2010
Sta	ite_	Katherine Thomas 31. Date filed (Month, Day, Year)			600 North Wo	olfe St, Baltimo	ore, MD, 21287
Registi	ar	JUL 192010	32. registrar's Signature	arked			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decement's Name (First, 2. Date of Death Physician/ Medical Facility Name (if ribt institution, give street and number **Examiner** inty of Death If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth ocial Security Number **Funeral** 1X M 2 □ F Days Country) 4-(Month 1947/ear) 63 Π 215-46-8291 Director Usual Residence of Decedent or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Pikesville MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 3920 Mladies Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: Specify: African-American 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) United Iron and Metal IIC. Crane Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lois Merrill William C. McDonald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 3920 Mladies Court, Pikesville, MD 21208 Barbara A. McDonald/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other p Arbutus Memorial Park 1 X Burial 2 Cremation 3 Removal from State 7-24-2010 Arbutus, MD Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 lar. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to home distact cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ledical Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Medical

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within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral

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the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records,

State Registrar 1 Tes

Natural

2 Accident

3 Suicide 4 Homicide

29b. Signature and title of certif

29a. Certifier

5. Was case referred to medical Hospital 2 XNo

27. Manner of Death 5 \square Pending

Investigation Could not be determined

28a. Date of injury (Month, Day, Year)

32. Registrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? M 2 🗌 No

Other:

26. Place of Death (Check only one)

1 Greatifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

performed Yes 2

28d. Describe how injury occurred

4 Nursing Home 5 Residence 6 ther (Specify

2010

1
Yes

□ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland /	Cer	irtment of H tificate of D	ieaith Death	and Me	ептаї ну	giene Reg. N	20	10	22351	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Deborah Makins							Date of De		1 7	201 0	3. Time of Death 2:02 A. M	
	Examin		4a. Facility Name (if not institution, give st Gilchrist Hospice	4b. City, Town, or Location of Death Towson				40	4c. County of Death Baltimore						
	Funeral Director		5. Social Security Number 6. Sex 212-60-6551	7. Age	e (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	Date of Bir	th 22 (ear)		9. Birthpl Counti	lace (State or Foreign	
ryland	permit. Page I and 2 should be misd within 72 hours after death with the invaryand Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	c. City, Town or Location Pikesville							10d. Inside City Limits 1 ☐ Yes 2 🎇 No		
ith the Ma		Funeral Director	MD Baltimor 10e. Street and Number 4621 Debilen Circle,		_	PIKE	10f. Zip Code	208			10g. Citizen of What Country?				
036 s after death v	ral", or items Examiner mu	ed by Fune		2. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If	3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:						- America c, White, e		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after	ne. than "natu ne Medical	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Seconday (0-12)	cation	41	(Give k life. DC	ent's Usual Occupa ind of work done do NOT use retired)	ation uring mo	st of working		16b. ł	Kind of Bus			
land 2.	ental Hygie ked other ic event, th	To Be C	12th 17. Father's Name (First, Middle, Last) Abraham Makins			HOUS	usekeeping Sinai I 18. Mother's Name (First, Middle, Maiden Surname) Mattie Butler						рпаг		
, Mary	ealth and M n 27 is mar er traumat		19a. Informant's Name/Relationship (Type Shawntay Mitchell/ Dat		1'		g Address (Street a					r Town, Sta	ate, Zip Co	ode)	
timore.	ment of He tant: If iten jury or oth		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place ceme King	of Disposetery, crem	sition (Name of atory or other place al Park	place) Date 7-23-2010 Date 20c. Location - City or Tow Woodlawn, MD ddress of Facility While Funeral Home P.A. of					vn, State		
Balt	Depart Import any in		Signature of Funeral Service Licensee	^{lity} Wylie I. Randa				A. of	Balto. Co.						
	Medical menusit the prival-transit	al Examiner	23a Pard . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spok, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death		
). Box 68760 the death certificate be		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)					23d. Date Mon	of deliver	ry Day Year			
dS, P.C quires that	been signed by the should be detached	by	Part II. Other significant conditions con-	ributing to death bu	ut not resulting	g in the ur	derlying cause give	en in Par	t I.	23e. Did to		1		e cause of death?	
Recor The law re	certificate has be irector, page 2 sho	Completed								24a. Was autop perfo 1 Yes		pr de		sy findings available inpletion of cause of	
Division of Vital Records, P.O. Box tal or Attending Physician: The law requires that the death or	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Certificate: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	28a. Date of injur (Month, Day, 28e. Place of Injur	Year) ry - At home,	o. Time of injury	Other 28c. Injury work? M 1 1	r: 4 🗆 N	□No	5 Resid	ow injui	ry occurred	d	Hospical	
Div ospital or	hours afte uneral Dir	Medical Ce	29a. Certifier 1 Certifying Physic	ian: To the best of or	ny knowledge						use(s) a	nd manner		I. se(s) and manner stated.	
To the H	within 2 ² To the F complete	Me	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the t				time, da		and due to the	e cause(ner as stat	ted.	
	2		30. Name and address of person who cor	npleted cause of de	eath (Item 23a	(Type, Pi	, /**	stu	£ . T	BUNS	(I	MO	21:	204	
	Stat Registra		31. Date filed (Month, Day, Year) JUL 19 2010	32. Registrat	1	Mad									

10-05100 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lillie McKnight State of Maryland / Department of Health and Mental Hygiene 2010 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/. Month D Day Medical Examine Lillie McKnight 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 541 N. Pulaski Street Baltimore NA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or If Under 24Hrs. **Funeral** Days Months Min Hours Director 62 10-26-47 239-76-0864 М Country) Usual Residence of Decedent 10c. City, Town or Location 10a. State is 23a or 28a-f show e notified at once. MD NA Baltimore hours after death with the Maryland rector 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 541 N. Pulaski Street 21223 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.African 1 Never Married 2 Married Yes è 1 Yes 2 No specify: f Yes, Give Year Specify: American Divorced "natural" ğ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) timore, MD 21215-0036

1. Pages 1 and 2 should be filed within 72 hou ment of Health and Mental Hygiene. Trans: If item 27 is marked other than "nat y or other trannatic event, the Medical Engrey or other Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade Seamstress Seamstress Co. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Unk. Be McKnight ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leven McKnight-Son 923 N. Fulton Avenue Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Department or Important: I injury or other Metro Crematory 07-15-10 Catonsville, MD 4 Donation 5 Other Specify: Signature of Funeral Service bicensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause of each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran sician/Medical UNPENDED **AMENDED** Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy use as t Fetal death Month Day Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death?

22352

NC

10d. Inside City Limits

1XXYes 2 No

Approximate Interval

Between Onset and

Death

Year

2 No

24b. Were autopsy findings available

death?

1 🗸 Yes

29d. Date signed (Month, Day, Year)

July 8, 2010

prior to completion of cause of

3. Time of Death

2030 hrs

Division of Vital Records, P.O.

director, page

signed by the atte has been si 2 should b this certificate filled in by the

State

Registrar

OCME 2006

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 至 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an autopsy performed? ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene ဥ 1 V Yes 28c, Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 1 V Natural Yes 2 No Certificati 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa

and manner stated 29b. Signature and title of certifier arol

Hallas

29c. License number O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Date filed (Month, Day, Year)

32. Registrar's Signature Darke

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2010 22353

,		1- For State Certificate of Death Registrar	, ,	j. No.				
Physicia	n/	Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death			
Medical Examir		GARY MORRISON	July 9, 201		1420 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De 4905 Reisterstown Road Baltimore						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. B	rthplace (State or			
Director	1	227-58-8730 1X M 2 F 69 Yrs. Months Days Hours M	-1940 Fore	ign ountry) VA				
	-	Usual Residence of Decedent	<u> </u>					
any	Ī	10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits			
and show	5	MD BALTIMORE			1 XX Yes 2 No			
Maryl 28a-	Director	10e. Street and Number 10f. Zip Code 21215	10	g. Citizen of What Co USA	untry?			
th the 23a or					the Indian Block			
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		White, etc.	rican Indian, Black,			
ter de		1 Yes 2 No 3 XXV/Vidowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: 121	LACK			
ours ad atural	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business				
6 72 ho cal Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	retired)					
withir jene.	Completed	12 BARBER	ame (First, Middle, M	HAIR	•			
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	BeC	17. Father's Name (First, Middle, Last) unk.	ime (Filst, Middle, M	alderi Surname) ui	ık.			
212 ould be Menti mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	or Rural Route Numb	per, City or Town, Sta	e, Zip Code)			
MD and 2 sho alth and arm 27 is	٦	SHARON HAMM/GRANDDAUGHTER 827 W. BARRE ST.	BALTIMORE					
Te, I and I and Heal	ſ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	r Town, State			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify: ON—SITE CREMATION CTR	7-16-2010	BALTIM	ORE, MD			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once.			AMES A. M	ORTON & SO	ONS F.H., INC.			
	\dashv	23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ST. BALT	IMORE, MD	21217 Approximate Interval			
Physician		failure. List only one cause on each line.		st, srioot, or riour	Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic cardiovascular d Due to (or as a consequence of):	isease		1			
		Sequentially list conditions, b						
	iner	if any, leading to immediate Due to (or as a consequence of):						
J=	Medical Examine	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):						
760, cate be executed physician and the bunial - transit	E E	d.						
760, cate be exc physician he burial -	gi	\square UNPENDED AMENDED 23a,27, per ME G905 7/22/10 TT		00 D (d)				
876 tificate ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the specific present 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic presents.	gnancy	23d. Date of delive Month	ry Day Year			
Box 687 e death certific the attending p	icia	4 Pregnant at time of death 5 Other (Specify)		1	(4)			
. Bc he dea y the a	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	I 23e Did tob	pacco use contribute t	the cause of death?			
P.O.	by	Part II. Other Significant conditions Continuously to death but not resulting in the underlying cause given in Part I.		2 √ No 3 Pr				
dS, squire	Completed				utopsy findings available			
COrd law re has by	nple		autops perform	ned? death?				
Re-		25. Was case referred to medical 26.Place of Death (Che	1 Yes 2	No 1 ✓ `	es 2 No			
/ital sician is cert	m	examiner? Hospital: 4 Inaction 2 EB/Outpetient 3 DOA Other, Nu		Residence 6 🗸 Oth	er: Scene			
of V ig Phy fter th	٩	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	****			
On endin sath. or: A	텵	Natural 5 Pending 1 Yes 2 No						
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	įįį	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Son Town, St		tural Route Number, City			
Dj spital nours a neral I	Ser	4 Homicide determined (Specify)						
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	ical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred						
To t with To t	Medical Certification:	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M				
		Monda in Mare Wall O.C.M.E.		July 10, 2010				
000		30. Name and address of person who completed cause of death (Item 23a)						
OK-PX		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201		53			
	ate	31. Date filed (Manth, Day, Year) 32. Registrar's Signature						
Regist	l ell	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\mathbf{J_{u}^{M}l_{v}^{ntr}}$ 1²4^y. 20°1′0 12:51 Barbara V. McAuliffe 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth August 29 1 □ M 2 🗶 F Days Hours Year) 9<u>33</u> West Virginia 233-52-9682 76 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Marvland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11421 Staten Court 20876 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15, Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bery1 Vickers Kathryn V. Lanham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. McAuliffe / Husband 11421 Staten Court, Germantown, Maryland 20876 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Ju1v 1 🗌 Burial 2 ី Cremation 3 🗀 Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 Donation 5 Other (Specify) Signature of Fundral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Months shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Breast Cancer with Metastases to Lung and Abdomen Due to (or as a consequence of):

Physician/ Medical Examiner Examine

permit. Page 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene.
Timportant: If item 27 is marked other ****
Tany, injury or other trainment.

Physician/

Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

Direct

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Completed

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12

Hospital or Attending Physician: The law requires that the death certificate be executed attending p for use as t within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

P.O. Box 68760

Division of Vital Records,

Completed by Physician/Medical

Be မ

Certificate:

Medical

29b. Signature and tile of certifier

Geoffrey Coleman,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

0		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):	
resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to medical	26. Place of Death (Check o	nly one)
examiner? 1 ☐ Yes 2 🎛 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 Residence 6 X Other (Specify) Hospice
27. Manner of Death 1 🕅 Natural 5 🗌 Pending 2 🔲 Accident Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	ff. Location (Street and Number or Rural Route Number, City or Town, State)
(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and one: On the basis of examination and/or investigation, in my opinion, death occurred at the separationer: To the best of my knowledge, death occurred at the time, date and place.	e time, date and place, and due to the cause(s) and manner state

29c. License number

D37142

1355 Piccard Drive, Rockville, Maryland 20850

29d. Date signed (Month. Day, Year, 7-15-2010

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year Physician/ Month 214 PM Melvin Anthony Miller 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death FRANKlin Saugue Hospital Center Bactimor & Rosedale 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Hours Min. (Month, Day, Mar vland 219-18-4308 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location with the Maryland than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Md. Baltimore City Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 506 South Lakewood Avenue 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 🙀 No Specify: Specify: 3 ₩ Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Music Musician per it. Page 1 and 2 should re filed with Der artment of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the any once. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Antoniette Chojnowski Miller John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4405 Necker Avenue Nottingham, Md. 21236 Jane Zientak -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ju1^{Date} cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 16, 2010Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus Cem 22. Name and Address of FaciliKaczorowski Funeral Home, . Signature of Funeral Service Licensee Moole Md.21222 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARRhamid disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ASC Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 含 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ₹ N 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gestigning in institution in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifi

D., .

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) **19201**0

mlia

32. Registrar's Signatu

24276

2801 Hudson St Suite A Balto

ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAMES S. NASUTA Physician/ Month / 16/2010 2:47 p.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE GILCHRIST CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days 1**X**□ M 2 □ F 216-20-8717 83 01/29/1927 MARYLAND **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE PARKVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 8322 EDGEDALE ROAD 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Seconday (0-12) College (1-4 or 5+) FABRICATOR MARTIN MARIETTA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FRANK NASUTA ANNA LAMBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS NASUTA/SON 8116 HILLENDALE ROAD BALTIMORE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕱 Burial 2 🗆 Cremation 3 🗀 Removal from State crestlawn MEM. GARDEN'S 07/22/2010 MARRIOTSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility BLVD. THE JOHNSON, FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, FMD 21286 21. Signature of Funeral Service Licensee MO0217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MARCH 2010 Medical resulting in death) Due to (or as a conse wince of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or). the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEGERMANIMO

29b. Signature and title of certific

DANIEUE 31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

364395

CHARLES STISHITE 4105 BALTIMINE, WO 21204

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 22357 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 13 Wilbert Ng 2010 5:45 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14234 Bauer Drive Montgomery Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Days Hours January 13 1 🕅 M 2 □ F China Director 551-36-5618 79 1931 Usual Residence of Decedent or 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 14234 Bauer Drive 20853 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever In U.S. Armed Forces?
1

Yes 2

No
If Yes, Give Year or Dates. 1952–1954 Black, White, etc. 2 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 😾 No Specify: "natural", 3 X Widowed 4 Divorced Specify: Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Central Intelligence Agency Analyst or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed the alth and Mental Hitem 27 is marked of မ Not Available Mae Gim Louie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Ng/Daughter Winding Rose Drive, Rockville, Maryland 20850 permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 👿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Montgomery Crematorium, July 19,2010 Inc Bethesda, 21. Signature of Funeral Service Licent Robert A. Pumphrey Funeral Home, Rockville, Inc. Haran M01530 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Years set and Death Physician/ disease or condition Congestive Heart Failure Medical resulting in death) Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events coulding in death). Coronary Artery Disease Due to (or as a consequence of) Examir Diabetes Mellitus Years and burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be the attending p JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) as been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2 🗌 No Yes 2 X No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending after death.

Director: After in by the fun 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Norse Practioner: To the best of m nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 29d. Date signed (Month, Day, Year) D36046 July 16, 2010

2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Registrar
DHMH 17 Rev 7/2009

State

30. Name and

John

J

3a) (Type, Print)

20215 Fernwood Rd. #405, Bethesda, Maryland 20817

erson who completed cause of death (Its

Merendino Jr.,

M.D.

32. Regist ar's Sign ture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22358 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year July 13. 2010 Catherine M. Orrell 4:30P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Perry Hall 4501 Talcott Terrace Unit Balto. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 21 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Maryland Director 215-16-5542 88 Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Md. Balto. Perry Hall 1 Tyes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 4501 Talcott Terrace Unit J 21128 USA death v 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by should be filed within 72 hours after 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) the Homemaker Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Hansen Katherine Kaiser 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 shour ment of Health and tant: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard F. Orrell Spouse 4501 Talcott Terrace Unit J Perry Hall, Md. 21128 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Important: If it any injury or o 1X Burial 2 Cremation 3 Removal from State Dulaney Valley 7-16-2010 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) UNC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe after death. Director: After this certificate Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 X Yes 2 \(\subseteq\) No Other: 힏 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1
Natural 5 Pending March 3,2010 2 XNo 1 Tyes MKNOWNM 2 X Accident Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 450; Rallcott Tex # Perry hall 70 determined Home To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Practioner: To the best of my knowledge, direct to at the firm, date and plane, and due to the nause(s) and manner as state 29b. Signatu pleted cause of death (frem 23a) (Type, Print) P 31. Date filed (M th, Day, Year, 2. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2235**9** Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 16: 13AM almere ando 2010 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Baltimore Bayview Medical Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sen 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 214-20-3089 Director 85 3-14-1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Examinat must be notified at 1XYes 2 No Director Baltimore Md 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 254 S. East Avenue 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ N If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Army Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Police Department 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daloia Rosa Nicola Nicholas Palmere ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Josephine Palmere - Wife 254 S. East Avenue Baltimore, Md. 21224 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Gardens of Faith 7-21-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Swice Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. S. Conkling St. Baltimore, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the dispesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** hom Myocardia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Examin burial-tran Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Uhknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

Division of Vital Records, P.O. Box 68760

funeral director, this After t death. 24 hours after death Funeral Director: filled in by completely within 2 To the

Certification: To

State

Medical 29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

5 ☐ Pending investigation

6 Could not be determined

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Bradley Strunk M.D 4940 tastern Avenue Baltimore 21224 C MD

31. Date filed (Month, Day, Year) 19

32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

Registrar

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydienes

			State Registrar			, y			cate of L		ila ivio		Reg. No.	010	22	2360
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2	Examir	ner	4a. Facility Name (if		give street and num Way, #1G				City, Town, or					County of Death		
7	Funeral	_	5. Social Security N		6. Sex	7. Age (In yrs.	last birth		Silver Inder 1 Year	If Under 2	<u> </u>	Date of Birl		on tgomer	3	ate o <i>r Foreig</i> n
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21215-0036	72 hours after death with the Maryland "matural", or items 23a or 28a-f sho fedical Examiner must be notified at	d by	1 ☐ Never Marr 3 🔀 Widowed		ed 1 🔀 Yes If Yes, Giv Year or Da	e		1 🗆 Y	es 2 🛭 No	Specify:			Si	pecify:White		
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Maryland	permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once.	To	Francis		lyde	Powde	rlv				abeth	rst, Middle,	<i>Maid</i> en Su	_{irname)} Barr∈	+ +	
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Box	of the	Physician/	in the past 12 n	nonths?	4 🔲 Pregr	Birth 2□ Fet nant at time of		3 Ector	pic pregnanc r (spec <i>ify)</i>	у			23	d. Date of delive Month	Day Day	Year
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$O_{\rm H}$	ician: The certificate ector, pag		25. Was case referre	d to medical	1				26 Pla	ice of Death	(Check only		med? 2 No	1 🗌 Yes	2 🗌 No	
N I	Physician: this certific al director,	욛ᅵ	examiner? 1 Yes 2		Hospital:	npatient 2	BR/Outp	atient 3	I Out-	<u>.</u> .	·		ence 6	Other (Specify)		
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Sior	l or Attendii after death. Director: A I in by the fu	Certificate:	2 Accident 3 Suicide	Investiga	ot be	of Injury - At h	ome farm	M street fac		Yes 2□No	-	Leastion (C			Dt- M	
For la ME	al or A s after il Direct ad in by	<u> </u>	4 U Homicide	determin	ed buildin	g, etc. (Specif	y)	, otroct, rac	itory, office		201.	City or Town	n, State)	lumber or Rural	Route IVI	imber,
` -	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this cartificate has been sign completed filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 (Check 2	Certifying F	Physician: To the beaminer: On the basi	est of my know	ledge, de	ath occured	d at the time,	date and pla	ice, and du	e to the cau	se(s) and r	manner as state	d.	
	To the Ho within 24 To the Fu complete		only one) 3 29b. Signature and t	Certifying i	lurse Practioner:	o the best of m	y knowled	lge, death o	ccurred at the	time, date an	nd place, an	d due to the	cause(s) a	nd manner as sta	ited.	
	5 with		▶ UNIV	tle of certifier	YOU(IX)	UM()	MJ)	29c. License	i.S.3	1	2	9d. Date s	signed (Month, E	ay, Year)	
		-	30. Name and addres	ss of person wh	p completed cause	of death (Iten	n 23a) (Tyr	oe, Print)	02	. , O J	1		700	7 1	ارب	140
	91		30. Name and address			0, 118	100	Did	<u>C</u>	vgeto	MU	Kd	·Ke	desil	e,	MU
	State Registra	e r	1. Date filed (Month	1 9 2010	32. Re	gistrar's Signa	ture	Kel		7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Balto Season's Hospice Randallstown
er 1 Year | If Under 24 Hrs 8. Date of Birth April 18,1944 Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** Months Days Hours Michigan Director 370-46-1475 Yrs 66 Jsual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛛 No Harford Fallston Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21047 USA 484 Stratford Road Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc 1 Never Married 2 Married ģ 1 Yes 2 No Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. ।। ਜਦs, ⊆ive Year or Dates. 1968 **–** 197⊉ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) **Retail** Small Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Frederick Reddel Mazie Roper and 2 should be Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 484 Stratford Road Fallston, Md. 21047 Drew Reddel Son permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 7-17-2010 Bayview Balto. Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy Por in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 6 Other (Specify this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending nours after death.

neral Director; A

filled in by the fu Accident 1 Yes 2 No Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signe

State Registrar cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar			Certificate of		Mental Hy	giene Reg. N	810	22362
	Physicia Medio		1. Decedent's Name <i>(First, Middle, Roslyn L</i>	,	on			2. Date of Dea		2010	3. Time of Death
	Examin		4a. Facility Name (if not institution, g			4b. City, Town, o	or Location of Death	17/	4c. C	ounty of Death	
	Funeral Director				yrs. last birth		If Under 24 Hrs.	8. Date of Bird (Month, Da Sept 2	th	9. Births	place (State or Foreign
	and show at	o	Usual Residence of Decedent 10a. State 10b. County	104	c. City, Town	or Location		10000			0d. Inside City Limits
>	Maryla 28a-f)irect		George's	Bowie						1 🖾 Yes 2 🗌 No
2	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Number 16302 Eastham	Court		10f. Zip Code 2071			USA	en of What Cour	ntry?
05C	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒Divorced	12. Was Decedent Ever in Armed Forces? 1	in U.S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🛣 No		pecify Yes or No- o Rican, etc.)		. Race - Americ Black, White, o Decify: Bla	etc.
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•	Medical Examiner		disease or condition resulting in death)			BREAST C	ANCRA				
	25	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor				- 16			-
M	ecut and and	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as a cor	nsequence o	n):					
260	icate be execut physician and s the burial-transit	edical		d		-					
Box 68	ath certif attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pr 1	Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify) _	ncy		23	d. Date of delive	ery Day Year
ls, P.O.	requires that the de been signed by the should be detached	É	Part II. Other significant condition	s contributing to death but no	ot resulting in	the underlying cause g	iven in Part I.				ne cause of death?
Division of Vital Records,	The law req ate has bee page 2 shor	Completed						24a. Was autop perfo 1 Yes		24b. Were autop prior to co death? 1 Yes	osy findings available mpletion of cause of 2 No
ital	ysician: The la iis certificate ha director, page?	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Tou	Place of Death (Chec	ck only one)		1	
n of V	nding Phys th. : After this s funeral di	cate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury (Month, Day, Yea	28b. Ti	me of 28c. Inju	4	ome 5 Residence 128d. Describe h)
ivisio	l or Atter after dea Director	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be 28e Place of Injuny		m, street, factory, office		28f. Location (S City or Tow		lumber or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral.	Medical	(Check 2 Medical Exa	Physician: To the best of my kaminer: On the basis of examinus Practioner: To the best	ination and/or	investigation, in my opin	ion, death occurred a	at the time, date a	and place, ar	nd due to the cal	use(s) and manner stated.
•	To the within the complete com		29b. Signature and title of certifier	Kino, MD		29c. Licens	se number		29d. Date 5	signed (Month, I	Day, Year)
	15		30. Name and address of person when MELVIN W. GASK	no completed cause of death	(Item 23a) (T	ype, Print)	DK. G	KEELIBE	ELT , 1	np 20	770
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's 9	_	A. South				- ·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	Sia	ite of ivial yla	Ce	rtificate of Deat	n and ivie th		leg. No.	IU	22363
	Physici	an	1. Decedent's Name (First,	Middle, Last)				2,	Date of Dea	th Day	Year	3. Time of Death
	/Medic		Frances		Iren	9	Robinso		uly_	17 2	2010	1:30pm
	Examir	er	4a. Facility Name (If not ins	1121	17 1	,	4b. City, Town, or Location		1	4c. County	of Death	
	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under 1 Year If Und	0 Y Coder 24 Hrs. 8.	Date of Birth	7 (500)	9. Birthp	place (State or Foreign
	Director		216-40-642	6 1□M 2	^{□XF} 67	Yrs.	Months Days Hou	rs Min.	3 02	43	Cour	MD
	and		Usual Residence of Deceder 10a. State 10b. C		10c. C	ity, Town or Lo	cation				T1	0d. Inside City Limits
	Maryl	tor	MD	NA		Baltim						1 X]Yes 2□No
	r 28a	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen of V	Vhat Cour	ntry?
	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, it a Madical Exartinal rust be maiffed.	raiD	9 Otley Ct	- Apt 28			21244			U.S	5 . A .	
	tems	Funeral	11. Marital Status	12. Wa	s Decedent Ever in U	J.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specifican, Puerto Ric	y Yes or No- an, etc.)			an Indian, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ X☐ Widowed 4 ☐ Div	If Y]Yes 2 MiNo es, Give ar or Dates:		1⊡Yes 2 X No <i>Sp</i> ec	cify:		Specify	B1	ack
21215-0036	2 hou	Completed by		ecedent's Education		16a. Dece	dent's Usual Occupation			16b. Kind of Bu	siness/Inc	dustry
215	thin 73 re. an "n	nple	(Specify only Elementary/Secondary (0		llege (1-4or 5+)	(Give	kind of work done during n DO NOT use retired)	nost of working	1	Spring	gfie	1 d
21	ed wil		11th grade	r	ıa	Nur	se Assista			Hospit		
and	l be fill he fill he del he	Be	17. Father's Name (First, M					,		Maiden Surnam	e)	
Maryland	should nd Me mark matic	은	Gilbert Do 19a. Informant's Name/Re		nt)	19h Maili	ng Address (Street and Nu	ances			State Zir	(Cade)
	nd 2 salth ar		James Tayl		,		Fifth Ave,					21227
ore,	es 1 a of He of He litem		20a. Method of Disposition	_	20b.		sition (Name of matory or other place)	Date		20c. Location -		
Ĕ	Page ment ant: It	35	1 Burial 2 □ Crem 4 □ Donation 5 □ Ot	ation 3 ⊟ Remova ther <i>(Specify)</i>	i irom State		orial Park	7/22/	201d	Woodl	Lawn	, Md
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item Adical Examination as 10 be mailled at once.	1	21. Signature of Funeral S	ervice Licepsee	himes	<u> </u>	Arch F/H W	est Ave	Balti	more.	Md	21215
			23a. Part 1. Enter the diseashock, or heart failure	ase, or complications	s that caused the dea							Approximate Interval Between
N.	Physician	Ĺ	Inmediate Cause (Final disease or condition				INPARCITO					Onset and Death
The state of the s	/Medical Examiner		resulting in death)		Due to (or as a conse		- TINFALCIEU					hour
	Examiner	<u></u>	Sequentially list conditions	b	CORONARY		ny disease	ggard?				10 years
8.	uted Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	` ₹	Due to (or as a conse	quence on:						
100	execting and and ial-tra	Examiner	that initiated events resulting in death) Last	С	ue to (or as a conse	quence of):				-		
376	tificate be executed g physician and as the burial-transit	ledical		d								
CC5 687		Med	IF FEMALE:									
Box	death cer e attendin d for use	Physician/M	23b. Was decedent pregna in the past 12 months	1 [es, outcome of pregr Live birth 2 ☐ Fet	aldeath 3[Ectopic pregnancy			23d. Dat	e of deliventh	ery Day Year
80	0 0	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	4L	Pregnant at time of Unknown	death 51	Other (specify)					,
To	The law requires that the ate has been signed by th bage 2 should be detache		Part II. Other significant co	onditions contributing	ng to death but not re	sulting in the u	nderlying cause given in Pa	irt I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
Z <u>\$</u>	w requires t s been signe should be o	ed by	DIABETES	MEZLITE	ی		<u>-</u>		1 □ Y	es 2□No	3 ☐ Prob	pably 4 Unknown
50 eco	e law re has bed e 2 sho	plet	HUPER	NB12436					24a. Was a	n 24b.	Nere auto	psy findings available mpletion of cause of
SINSON tal Records,	The I	Completed	. //						perfor 1 ☐ Yes	med?	death? ∐Yes	
O Vita	Physician: The r this certificate ral director, pag	Be (25. Was case referred to me examiner?					ace of Death (C				
€ £		2	1 ☐ Yes 2 ☐ No 27. Manner → eath	Hospital 28a	: 1 ☐ Inpatient 2 ☐ . Date of Injury	ER/Outpatier 28b. Time o				ence 6 □Oth ow injury occurr		(y)
on	ding th. After funer	tion	1 → atural 5 ☐ F	Pending nvestigation	(Month, Day, Year)	Injury	f 28c. Injury at Work? M 1 ☐ Yes 2		J. Describe fi	ow injury occurr	eu	
Division	Atten r dear ector: by the	ifica	3 ☐ Suicide 6 ☐ C	Could not be	Place of Injury - At h building, etc. (Spec	ome, farm, str			. Location (S	treet and Numb	er or Rura	al Route Number,
Ö	tal or rs afte al Dir	Certification: To	4 D Hornicide		building, etc. (Spec	iiy)		-	City or Tow	n, State)		
	To the Hospital or Attending Physimithin 24 hours after death. To the Funeral Director; After this completely filled in by the funeral di	Medical	29a. Certifier 1 ☐ Ce (Check only one) 2 ☐ Me	edical Examiner: O	To the best of my kn the basis of examin d manner stated.	owledge, deat ation and/or in	h occurred at the time, date vestigation, in my opinion,	e and place, and death occurred	d due to the o	cause(s) and madate and place,	anner as s	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of o		· ·		29c. License numb	er	2	29d. Date signe	d (Month,	Day, Year)
			Genne &	Aug Our m	>		D 62641	_	-	JULY 17	12011	0
	3		30. Name and address of p	erson who complete	d cause of death (Ite							
	Sta	te	31. Date filed (Month. Day.	Year)	Registrar's Sign	ature-		re mo	2122	7		
	Registra		JUL I	92010	Serve ,	1. pa	Med					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22364 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O7 2010 17:10 M Rollins Marceline Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Good Samaritan Hospital</u> Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🗆 M 2X F (Month, Day, Year) 02 26 Months Hours Director 214-24-1565 83 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 <u>1308 Lakeside Ave</u> U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. Black Completed 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade 2yrs Homemaker House Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever Esther Burwell George C. Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Lakeside Ave, Baltimore, Md 21218 <u> Mark Williams-Son</u> Itimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 7/21/10 Arbutus, Md atura of Funeral Service Licensee Marchand Adoress of acility 4300 Wabash Ave, Baltimore, Md 21215 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 day m diate Cause (Final Severe Physician ase or condition resulting in death) Medical Due to (or as a consequence of): Examiner Bowel mall Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-transi that initiated events Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Artery Disease Dyslipidemia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? Hypertension, Anemia 24a. Was an autopsy performed? Yes 2 No 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760

ROLLIN

ARCELINE

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

1 Natural

☐ Accident

4 Homicide

Suicide

5 Pending

Investigation

Could not be

determined

Certificate: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-00 METVUCCI, HOD 07/13 MARIA HENUCCI, MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Blvd. Baltimore, HD, 21239 31. Date filed (Month, Day, Year) State Registrar's Signatu 19201

Registrar

1 Tyes

2 🗌 No

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 10 22365 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sadler July 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7119 Mt. Vista Road Kingsville Balto. 7. Age (In yrs. last birthday) Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 F Months Hours Country **Director** 216-32-2237 anuary. Maryland Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Directo Md. Balto. Kingsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7119 Mt. Vista Road 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 ☐ Never Married 2 🖾 Married þ Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: "natural", Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filled within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Şeconday (0-12) 12th College (1-4 or 5+) Director of Business Development Distruction Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John V. Sadler May Rolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 i 7119 Mt. Vista Road Johanna Sadler Kingsville, Md. 21087 Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bayview 7-17-2010 Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has leted filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Natural injury 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

Box 68760

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of Marylan				Mental Hy	giene		
		State Registrar		Cer	tificate of E	Death		Reg. No.2 0	10	22366
Physic	ian/	1. Decedent's Name (First, Middle, Last			1		2. Date of De Month	Day	Year	3. Time of Death
Med	lical	Everett 4a. Facility Name (if not institution, give:	A.	Sta	nard	Location of Death	July 1	4c. County	of Dooth	10:00 A M
Exam	iner	3105 Arundel Rd.	areer and namber)		Mount Ra					orge's
Funera	at	5. Social Security Number 6. Se		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birthp	lace (State or Foreign
Directo		230-44-4903	Дм 2 □ ғ	Yrs.	Months Days	Hours Min.	April I	6, 1938	Vir ₂	inia
d ow	٦.	Usual Residence of Decedent 10a, State 10b, County	100 0	y, Town or Loc	ation					0d. Inside City Limits
ryland -f sh	cto	,							'	1 Yes 2 X No
e Ma r 28a notif	Director	Maryland Prince G	eorge's Mot	ınt Rai	nier 10f. Zip Code			10g. Citizen of V	Mhat Cour	
/ith th 23a o st be	ra	3105 Arundel Road			20712			U.S.A.		ay.
ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-		e - Americ	an Indian,
er de mine	by	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No 3-	lf .	Yes, specify Cuba		Rican, etc.)		k, White,	
Z15-UU36 in 72 hours after e. nan "natural", o Medical Exam	ted	3 🗆 Widowed 4 ื Divorced	Year or Dates. 1968	1	☐ Yes 2 🖾 No	Specify:		Specify:	Blac	k
"2 hor	Completed	15. Decedent's Ed (Specify only highest gra-		(Give k	ent's Usual Occupa ind of work done o	ation Iuring most of worl	king	16b. Kind of Bu	usiness Ind	dustry
thin 7	Į,	Elementary/Seconday (0-12)	College (1-4 or 5+)	1	o <i>not use retired)</i> e Depart	ment		U.S. G	overi	nment
Hygie ent, t	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surname	e)	
lan be fil lental rked tic ev	욘	Lawrence Stanard				Dallie 1	Woodfoll	ζ		
ary		19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailin	g Address (Street a	and Number or Rui	ral Route Numbe	r, City or Town, S	State, Zip C	Code)
, March		Robert E. Stanard	- Son	6120	Pattillo	Way, Li	thonia,	GA 3005	8	
Ore e 1 ar e 1 ar e 1 ar e 1 ar or oth		20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆			sition (Name of natory or other plac		Date	20c. Location -	City or To	wn, State
Baltimore, Maryland semit. Page 1 and 2 should be filed Department of Heath and Mental Hymportant; If item 27 is marked oth may injury or other traumatic even		4 Denation 5 Other (Specifi) Stan		vis Ceme		17/2010		1vani	la, VA
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		21. Sign ture of Funeral Service Linense	Mu	A A 2	Name and Addres L. Benne 00 Butter	s of Facility Ett & Son Inut Dr.,	Funera Freder	1 Home	g, VA	22408
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or		_						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	. Stomach Can	cer						Onset and Death
Medica Examine		resulting in death)	Due to (or as a conseq	,						
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Mag' tig	Examiner	cause. Enter Underlying Cause (Disease or iinjury								
be execut sician and burial-tran	Ä	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						-
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oertifica ding plase as t		IF FEMALE:	20- 16			-				
BOX the death cender the attended for us	ian	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of	aldeath 3 🗌	Ectopic pregnanc Other (specify)	;y			te of delive inth	ery Day Year
the a	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown	deam 5 L	otilei (specily)					
that the	by Pi	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contr	ribute to th	ne cause of death?
uires n sigr	ed b	-					1 🗆	Yes 2 🔀 No	3 🗆 Prol	oably 4 🗆 Unknown
VItal Kecords, ysician: The law requires is certificate has been sig director, page 2 should b	Completed						24a. Was		Were auto	psy findings available mpletion of cause of
KeC The la	l e						perfo	rmed?	death?	
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hysic his ce	은	1 ☐ Yes 2 🛣 No	fospital:			4 ☐ Nursing H	1	dence 6 Othe)
DIVISION OT tal or Attending Ph rs after death. al Director: After th ed in by the funeral	Certificate:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe h	now injury occurre	ed	
Atter Atter er dea ector by the	ertiţi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, stre	et, factory, office		28f. Location (\$ City or Tox	Street and Number	er or Rural	Route Number,
UN ital or urs aft ral Direction										
DIVISION OF VITAL RECORDS, P.O. BOX 65/61. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examin	ician: To the best of my know ner: On the basis of examinatio e Practioner: To the best of m	n and/or invest	igation, in my opinic	on, death occurred a	at the time, date a	and place, and due	e to the car	use(s) and manner stated.
To th Withii To th comp		29b. Signature and title of certifier			29c. License			29d. Date signed		
		1 m			D6498	33		July 13	3, 20	10
C		30. Name and address of person who co				11 12	0.21-	C	MD	20002
ď		Kashif A. Firozv	i, MD 32 Registrar's Signa		Medical F	ark Dr.,	Silver	spring,	TID.	20702
St Regis	tate trar	31. Date filed (Month) Pay, Year) 9 20	10 Segistrar's Signa	turg. Apr	Peled					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death July Physician/ Medical ^{Day} 2010 8:50 18. William Lazaros Siskos 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice Casey House Rockville Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Davs Hours Min. October 20. Greece 80 Director 060-30-3890 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at rector 1 ☐ Yes 2X No Maryland Montgomery Bethesda 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States/Greece 8208 Cindy Lane 20817 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. 9 <u>م</u> 1 Never Married 2 X Married 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural", Specify:White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5 Bechte1 Civil Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lazaros Siskos Olympia Stefani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Siskos/Daughter 125 Opossum Hill Road, Aspers, Pennsylvania 17304 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Important: If ii any injury or o 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) July 23, 2010 Silver Spring, Maryland Gate Of Heaven Cemetery Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 MO1530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Mitral and Aortic Valve Stenosis Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam that initiated events resulting in death) Last that the death certificate be execu Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 2 🗌 No 1 Tes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 ☐ Yes 2 🗓 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred XNatural 5 Pending work? thin 24 hours after death.

the Funeral Director: Afte mpleted filled in by the fun Investigation Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) 7-18-2010 37142

25

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

Registrar
DHMH 17 Rev 7/2009

1355 Piccard Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman,

Date filed (Month, Day, Ye

M.D.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#10a, perFH, G906, 8/3/2010, WS

State of Maryland / Department of Health and Mental Hygiene 22368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month STAUFFER DONALD, 2010 1:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UniVERSITY OF MARYLAND Medical (w BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Ye 11-4-1923 1 🕅 M 2 🗆 F Months Days Hours Min 197-24-4577 Director Pennsylvania 86 Usual Residence of Decedent should be filed within 72 monoconand Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show marke event, the Medical Examiner must be notified at 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19800 Tranquility Circle 21742 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tanker Driver Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wayne C. Stauffer Anna Andes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st it of Health a If item 27 is Marie Royce - Daughter P.O. Box 184 Funkstown, MD 21734 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) any injury or St. Peter Lutheran Cem. 07-19-2010 Lancester, PA 21. Signature of Mineral Sen ce Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Eye, he disease or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a least failure. Let only one cause on each line. Approximate shock, art failu Immediate C use (Final Interval Between Onset and Death Physician/ DIFFICILE disease or condition resulting in death) LOSTRIDIUM Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phys 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed Prednisona Were autopsy findings available prior to completion of cause of 24a. Was an autopsv performed? death? 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical director, B B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred work' 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the Within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN 07, 14, 2010 D69499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical IMC, BALTIMORE, MD 21201 22 5 GREENE GANJI 32. Registra 's Signature Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		for State Registrar		oldio o,	mar y lar		Certificate d					2010	22369
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/Medic	al	Rodney 4a. Facility Name (III	Darı	-)	Comblin	1	4h City Tour	0 0 1	ocation of Death	July 1		c. County of Death	3:07 PM M
Examin	er		gton Adv	entist Ho		L	Takom	ıa I	Park _			Montgomer	у
Funeral		5. Social Security No		Sex 7 1 □X0M 2 □ F	. Age (In yrs.	last birtho	Months Da		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Yea <i>i</i>	r) Coun	/
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ter de	Fun	11. Marital Status 1 ₩ Never Marrie	ed 2 Married	Armed Ford	es?	.5.	 Was Decedent of If Yes, specify C 	Cuban,	, Mexican, Puerto	Rican, etc.)		14. Race - Americ Black, White, e	etc.
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shoul and M s mar umat	۲	19a. Informant's Na				19b. N	failing Address (Str					or Town, State, Zip	Code)
and 2 salth a n 27 is er tra		Ray A. To	omblin -	Father		10	5 Glendal	Le	Circle,	Winches	ter	, VA 226	02
ges 1 If iten or oth		20a. Method of Disp		☐ Removal from St	20b. F	Place of D cemetery,	isposition (Name of crematory or other p	f place)	, i r	Date	20c. l	Location - City or To	wn, State
t. Pag rtmen tant: ijury		4□Donation	5 ☐ Other (Spec	ify)	Te Ce	mete	crematory or other in Hebron ry					chester,	
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination at the retified at once.		21. Signature of Fu	neral Servide Lice	nsee	0,		22. Name and Ad	ldress	-			ral Home, , VA 2260	
	(23a ar . Enter th	ne disease, or cor	nplications that car	used the deat	h. Do no	enter the mode of	dvina.				, VA 2200	Approximate Interval Between
Physician	4	s k, or hear Immediate Cause (rt failure. List onl Final	one cause on ea	ch line.	1	Sis	, ,		. ,			Interval Between Onset and Death
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Physician: The lav r this certificate has ral director, page 2.9		examiner?			<u> </u>	- `	atlent 3 DOA	Other:	4 LI Nursing no	me 5 ☐ Resid	dence	6 ☐ Other (Specif	y)
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To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical C	29a. Certifier (Check only one)	1⊟ Certifying F 2□ Medical Exa	thysician: To the barriner: On the barriner	sis of examina	ation and/	or investigation, in n	ny opi	inion, death occur	red at the time,	date a	(s) and manner as s nd place, and due to	the cause(s)
To the within 2 To the complex	Me	29b. Signature and	title of certifier	F(,	MD		29c. Lic	ense	0 60 60		29d. D	Date signed (Month,) 7 / 2	Day, Year) — Lc
2		30. Name and addre	ess of person who	completed cause	of death (Iter	n 23a) (T)	pe, Print)	14	MINA	14	90	ym to	
Stat	te	31. Date filed (Mont	_		gistrar's Signa	iture	1	_					
Registra	ar		JUL 192	010 2	una	1.	grand						

Registrar DHMH 17 Rev 1/2001 10-05069 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 22370 Anthony Woodard 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D July 6, 2010 **Medical Examiner** Woodard 1709 hrs InThony 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Funeral Hours Director 1 M 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 23a or 28a-f show notified at once. Bult more hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA HERROM Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital-Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 2 1 No BLACK 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ò 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n Odd Labor 17. Father's Name (First, Middle, Last) Woodand MCNEILI 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto Ned Park AVR CorteRCUM 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 13 1 Pinty Comstere 4 Donation 5 Other Specify 22 Name and Address of cility 21. Sign ware of Funeral Service Licenses 234. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö <u>چ</u> 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Records, 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 ✓ No death? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital or Attending Physician: Division of Vital Be Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 🗸 Natural 1 Yes 2 No Director: d in by the f Pending within 24 hours after death. Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number O.C.M.E. July 7, 2010

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

State

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

19

OCME

Victor Weedn MD JD

31. Date filed (Month, Day Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

10-05114 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 22371 State of Maryland / Department of Health and Mental Hygiene lesha Robinson-Whitley 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner Iesha Robinson Whitley 1031 hrs July 8, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10 Otley Court Apt. 3B Windsor Mill **Baltimore County** 5. Social Security Number 8. Date of Birth(MM/DD/YYYY 9, Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Min Months Davs Hours Director 07-18-88 218-23-1881 21 Country) MD 1 M Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. Count 10c. City. Town or Location MD NA Baltimore 1 X Yes 2 No or 28a-f shov or items 23a or 28a-f shormust be notified at once. with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6904 Richardson Road 21207 USA mit. Pages I and 2 should be filed within 72 hours after death with sarment of Health and Mental Hygiene.

"Tant: If item 27 is marked other than "-"

or other traumatic even". 14. Race - American Indian, Black, White, etc. African Funeral 12. Was Decedent Ever in U.S. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 2X No Yes 1 Yes 2 No specify: specify: American 3 Widowed 4 Divorced If Yes, Give Year þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade NA Disabled Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Whitlev James Angie Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Angie Butler-Mother 6904 Richardson Road Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 07-15-10 Randallstown, MD King Mem. Pk. Cem 4 Donation 5 Other Specify Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 2121 Approximate Interval Between Onset and ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on eat /Medical Thyrotoxicosis due to Hyperthyroidism (Grave's Disease) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit sician/Medical AMENDED 1,23a,27 per me g907 9-8-10 vt X UNPENDED attending physician or use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Fetal death Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown has been signed by the att 2 should be detached for Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes page ✓ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 X Natural Division 1 Yes 2 No death. Pending To the Funeral Director: completely filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME July 9, 2010 M. Brasse 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 32. Registrar Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Doris Jean Wickless 2010 12)alu 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOSPHA Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Himore 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 □ M 2 🕏 F Vear) Months 212-36-5671 70 1940 6, June Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore Lansdowne 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number First 1/2 21227 USA Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 MD State Tax Assessment Data Processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Howard Wickless Regina Agnes Andrews 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 680 Lake Drive, Westminster MD 21158 James H. Wickless Jr.-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2 ☐ Cremation 3 ☐ Removal from State Burial Donation 5 ☐ Other (Specify) July,16,2040 Holy Cross Cemetery Brooklyn Park MD Funeral Service Dicent 22. Name and Address of Facility Ambrose Funeral Home INC. 1328 Sulphur Spring Road, Arbutus MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset,and Death Immediate Cause (Final Due to (or as a consequence of): day disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10015 Live Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 □ Unknown 9 Unknown t I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ► HO 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "no any injury or other traumatic event. In Market 1000.

Physician

Examiner

10a. State

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Director

Funeral

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Physician/Medical

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Certification: To

Medical

MD

Funeral

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ir than "natural", or items 23a or 28a-f show

filed within 72 hours after death with the

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division of Vital Records.

/Medical

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director, this funeral c death. 24 hours after deat Funeral Director;

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	Part II. Other s
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Part II. Other significant conditions	contributing to death	n but not resulting in th	ne underlying cause gi	iven in Par
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Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient 2 ER/Outpatient 3 DOA

1 Yes 2 No 27. Manner of Death 1 Matural
2 Accident

3 ☐ Suicide

4 Homicide

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be determined

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tile of certifie

29c. License number

29d. Date signed (Month, Pay, Year)

BALTIMORE MD 21229

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 9

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🍎 🦍 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1415 M Wieber Bertha Elizabeth 2016 July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Somerford Pl. Alzheimer Facility Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Days Hours Min. 19926 1 □ M 2 🛣 F Maryland 220-18-8455 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Baltimore Halethorpe 1 □ Yes 2/CXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 USA 4411 Fenor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
 1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Leroy Sluss Anna Mary Holden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecilia Groszer, daughter 1133 Elm Rd. Halethorpe, MD. 21227 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Loudon Park Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-12-2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Izheimeris Immediate Cause (Final 4 years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 **X**No

Physician /Medical Examiner law requires that the death certificate be executed burialattending physician for use as the burial signed by the a P.O. Division of Vital Records,

page 2 certificate After this certification hours after death.

neral Director: Af
y filled in by the fur 24 hours a

Physician

/Medical

Examiner

Funeral

Director

28a-f show

death .

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Physician/Medical

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Medical Certification: To

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, IPe Modell Examination must be notified at

a filed within 72 hours after de al Hygiene.

12 should be filed with and Mental Hygier 7 is marked other the

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permit. Pages 1 an Department of Heal Important: If item 2 any injury or other

other t

Baltimore, Maryland 21215-0036

State

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Hospital or Attending

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner⁴ Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Tes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 🗷 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

56531

29d. Date signed (Month, Day, Year)

pany #301, columbia, mD21045

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li 8600 Snowden River 31. Date filed (Month, Day, Year) JUL 19 2010

29b. Signature and title of certifier

32. Registrar's Signature

MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 22374 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)

MARY MARGRET WIRTH 2. Date of Death 3. Time of Death OMonth Physician/ 2010 7:07 р. м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MADONNA HERITAGE ASSISTED LIVING **JARRETTSVILLE** HARFORD Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 0444311920 Hours 1 M 2 X F 212-10-9405 MARYLAND Yrs. Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Funeral Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified MD BALTIMORE PHOENIX 1 🗆 Yes 2 🔀 No 10e, Street and Numbe 10f, Zip Code 10g. Citizen of What Country? 11 WETHERBEE COURT 21131 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) DESK CLERK BLACK & DECKER YEARS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SAMUEL BURNS MARY C. ALLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENE H. WIRTH, JR./SON 11 WETHERBEE COURT PHOENIX. MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State MORELAND ME. PARK 07/21/2010 HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eyneral Service Licensee 22. Name and Address of Facility 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 MOO217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CAF disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PSC & D Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or illingry that initiated events Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death
Unknown Yes 2 Litto g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 Probably 4 Unknown PUD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate h
completed filled in by the funeral director, page Demonto 1 🗌 Yes 2 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No Certificate: To 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 M Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 \square No ☐ Accident ☐ Suicide Investigation 6 Could not be

Registrar

State

4 - Homicide

29b. Signature and title of certifier

29a. Certifier

31. Date filed (Me

determined

K10057

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours

Medical

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

mo

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar's Signat

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2<u>010</u> Month July Physician/ Glen Herbert Young 16, Рм 3:28 **Medical** 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Towson Gilchrist Center For Hospice Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 12, 1928 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours West Virginia 236 40 6518 Director 82 Feb. Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 N. Stuart St. 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, ò 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Captain of Security Steel Mill Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James A. Young Anna Mae McCombs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 353 Green Aspen Ct. Millersville, Maryland 21108 Alan M. Young (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Gardens Of Faith Cem. 7/20/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Signature of Funeral Service Lie Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Metastatic Carcinoid disease or condition receve Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🗌 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be OKID 1 Yes 2 No 3 Probably 4 Unknown CAD 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autonsy page performe 1 Yes 2 No Yes 2 **N**No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 2 K No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury e Hospira. C. n 24 hours after death. he Funeral Director: Aft 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D0070635

State

DHMH 17 Rev 7/2009

Registrar

Baltimore

LAURA PATEL MO

MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charle

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#20b, perFH, G905, 7/20/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 4a. Facility Name (if not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, 5. Social Security Number 16. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Nigeria Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 0a. State 10c. City. Town or Location 10d. Inside City Limits at 1 Yes 2 No Director Laure Examiner must be notified . Street and Number 10f. Zip-Code 10g. Citizen of What Country? MuirKirk 0708 Nigeria Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. igerian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Microbiologis event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ည traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: if item 27 is any injury or other trauonce. Amanchukwu Husband Koua 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/20/2010 Amanchukwu Cemetery . Signature of Funeral Ser Greene 1.0. 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, Immediate Cause (Final **Physician** inoma disease or condition resulting in death) +00 /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed after death.

Director; After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death page 2 should be detached 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 npatient 1 ☐ Yes 2 X No 4 Nursing Home 2 ER/Outpatient 3 🗆 DOA 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation Injury М 1 TYes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours aff To the Funeral Di A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) MD 2010 13 30. Name and addre completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ars MD

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 22377 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ July 15. Akins 2010 James E. 5:30 a. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collington Nursing Home Mitchellville Prince Georges 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months Davs Hours Min. Oct 15ay, Year 1926 277-22-2526 83 Director Ohio Usual Residence of Decedent items 23a or 28a-f shov 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince Georges Mitchellville 1 Yes 2XX No. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10450 Lottsford Rd., Cottage 5108 20721 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1944-Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 1946 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ambassador US Foreign Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Quay Akins Bernice Bixler traumatic and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 permit. Page 1 and .
Department of Health
Important: If item 27
any injury or other tra (wife) 10450 Lottsford Rd. Cottage 5108, Mitchellville, MD Marjorie A. Akins 20a. Method of Disposition
1 ☐ Burial 2 🏅 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 17. 20c. Location - City or Town, State 2010 Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or common in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Malignant Cardiac Arrythmas Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension, Deep Venous Thrombosis Lower Extremities Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? Yes 242No 2 🗌 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 9 1 Tyes 2 ី No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fitle of ce 29c. License number 29d. Date signed (Month, Day, Year) D66658

Registrar

DHMH 17 Rev 7/2009

State

Rexford Babilah, M.D. 7500 Hanover Pkwy. Suite 101A, Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 22378 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 1815 PM 5+ edas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Med. Baltimore N?A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 □ F Days Hours Min. Months 109377760 Newntry Director 215-78-2559 49 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If fire 72 is marked other than "nature." 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits N/A 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3520 Chesterfield Ave. 21213 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Completed by Black, White, etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Disability Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elnora Cockrell William Moody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elnora Moody(mother) 3520 Chesterfield Ave., Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 07/23/10 Baltimore, MD 21. Signature of Funeral Service Licens Joseph Admess of Bridwn Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Itisystem gan disease or condition resulting in death) Medical Examiner Methicillin Resistant Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Human Immuno deficiency that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Pretail Call
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy certificate Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 2 X No Other: 1

Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manger of Death 28c. Injury at work?
1
Yes Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 🗆 No Accident Investigation the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in this opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5310 17,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 0+

Signature

Dept

32. Registra

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31. Date filed (Month, Day, Year)

en

225. Greene St

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	State of Ma					-		_	•
	•	For State Registrar	State of Ma	i yiaiia /		tificate of l		•	Reg. No	0010	22379
Physicia Medic		1. Decedent's Name (First, Middle, La	st)	7 DIG	=1 N	5		2. Date of De Month			3. Time of Death
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Funeral	_	5. Social Security Number 6. 3	Sex 7. Age	(in yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir	th Voar	9. Bir	thplace (State or Foreign
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s 23a o	Funeral Director	7808 Edgewood A	venue			21122				SA	
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age 1 a ent of H nt: If ite y or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other Spec		20b. Place ceme	of Dispos tery, crem	sition (Name of natory or other plac	ce)	Date	20c. Lo	ocation - City or	Town, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of uneral Service Licer	///	tor	22.	Name and Addre	soffacility Bo	ard: 65	5 W.	Baltim	ore Street
2012	Ш	23a. Part 1 Enter the disease, or con	1119		\Box	Raltimo:	re, Maryl	and 2120	01		
Physician/		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	C)		CREA		or respiratory an	lest,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	a. Due to (or as a c	consequence		CICLI	/				711010377)
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eath certificate b attending physic for use as the b	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	Fetal dea		Ectopic pregnand Other (specify)	СУ			23d. Date of de Month	livery Day Year
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Exam		mination and	/or investi	gation, in my opinio	on, death occurred	at the time, date a	nd place	, and due to the	cause(s) and manner stated
To the within 2 To the comple	Ž	only one) 3 L Certifying Nur 29b. Signature and title or certifier	rse Practioner: To the be	est of my kno	wledge, d	eath occurred at the 29c. License	number	ace, and due to the		s) and manner as a signed (Mont	
		* Multo	ANTAV)		172	1438		yeu	714	2010
		30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Pi	ENSE	+ 1GAWAY	ANNA	90215	Mou	164
State Registra		31. Date filed (Month, Day, Year) 2	0 20 0 Registrar's	s Signature	A.	bark					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cecilia Anato		Sta 1- For State Registrar	ate of M	laryland /		artment of rtificate of		ind l	Mental Hy	_	Reg. No	20	0	22380
Physici Medical Exami		Decedent's Name (First, Middle	cilia	Anr	n	Amato				2. Date of De Month July 12, 2	ath Day	Year		3. Time of Death 0159 hrs
		4a. Facility Name (if not institution			-				cation of Death			c. County of	Death	
		University Hospital	6 604	7 400	(In .um I	last histhele.	Baltimore		Millerden Odilen	Data of D	lieth (A 4A 4	N/A		releas (Chata-
Funeral Director		5. Social Security Number	6. S ex			ast birthday)		ear ays	If Under 24Hrs. Hours Min.	1	·	1:	Foreign	nplace (State or
		215-40-5891 Usual Residence of Decedent	1 M 2	XF		68 Yrs				Oct.	<u>13,</u>	1941	Cou	ntry)Maryland
any		10a. State 10b. County		1	0c. City,	Town or Locat	ion							10d. Inside City Limits
Maryland 28a-f show d at once.	ä	Maryland Howa	rd			Ellicot	t City							1 Yes 2 X No
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th wit tems 2	Funeral	11. Marital Status 1 Never Married 2 X Ma	12. W	/as Decedent E rmed Forces?		.S. 13. Wa	s Decedent of es, specify Cub	Hispar oan, M	nic Origin? (Sp exican, Puerto l	ecify Yes or N Rican, etc.)	0-	14. Race - White,		an Indian, Black,
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Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is nijury or other traumati		20a. Method of Disposition 1 X Burial 2 Cremation				Place of Dispos crematory or oth	ition (Name of	cemete	ery,	Date		Location - C		
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Baltimo permit. Page Department of Important: injury or otd		21. Signature of Funeral Service	icensee		1000	22. N	ame and Addre		Facility Ru					Home:, Inc.
		23a. Part I. Enter the disease, or	Taga		o domin		0 York			wson, l			212	
Physician /Medical		failure. List only one cause	n each line.		ie deam	Do not enter tr	ie mode or dyn	ig, suc	n as cardiac or	respiratory ar	rest, sn	ock, or near		Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		or as a consequence	uence of	f):							\dashv	Death
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Box 68760 he death certificate the attending phys	N/C	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		If yes, outcome Live birth	of pregr	· -			Ectopic pregnar		23	 d. Date of de Month 	elivery Da	y Year
Box 6 e death cer the attendi	sicia	1 Yes 2 No 9 Unki	4	Pregnant at tin	ne of de	ath 5 Oth	ner (Specify)							
the de	Physician/M	Part II. Other significant condition	9	Unknown	ut not re	esulting in the u	nderlying cause	a aiver	in Part I	23e Did t	obacco	use contribu	te to th	e cause of death?
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Ď					-		- 3				_		bly 4 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed									24a. Was				psy findings available
COI e law e has l	dm									auto perfo	rmed?	dea	th?	mpletion of cause of
tal Rec		25. Was case referred to medical	T -				26.Pla	ce of D	Death (Check or		2 N		Yes	2 No
Vital I hysician: this certifi	o Be	examiner? 1 Yes 2 No	Hospital:	1 Inpatient	2 🗸	ER/Outpatient	3 DOA	Othe	er. 4 Nursing	Home 5	Reside	ence 6	Other:	
fing Ph	Ë	27. Manner of Death	16.0	i. Date of Injury Month, Day Year II 11, 2010	r)	28b. Time of Ir				2Bd. Describe			truck	by car and
Sion vittend death. ctor:	atio	Pendi	gation			2009 hrs			2 No e	jected				
Division piral or Attendir ours after death. teral Director: A	Certification:	deterr	not be	e. Place of Injur			t, factory, office	buildi		or Town, S	State)			Route Number, City
Lospita t hours unera		29a. Certifier 1 Cortified Physics		the best of my k			and at the time	data a		Rt 40 and Ma			-	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(0.100.1.01.1)	iner: On the	basis of examir	_									
T iv	Me	29b. Signature and title of certifier	and ma	anner stated.			29c, Licer	nse nu	mber		29d.	Date signed	(Monti	n, Day, Year)
		Chri	11	1			0.0	.M.E	i.		July	12, 2010)	
	İ	30. Name and address of person v			,		-							
			ssistant N	Medical Exa				itimo	ore, MD 212	U1				
St Regist		31. Date filed (Month, Pay, 22)	2010	32. Registrar's		D. Spa	Ves)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22381 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 18, 2010 4:43am John Paul Amoroso, III Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil 326 Elm Street Perryville Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Months Days Sept. Day, Year) Hours 1963 New Jersey Director 46 212-94-4527 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Yes 2 No Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 326 Elm Street 21903 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) driver delivery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John P. Amoroso, Jr. Dianne Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 Woodland Green Ct., Aberdeen, MD 21001 Dianne Amoroso (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Comp. 7/19/2010 West Chester, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Physician/ ancer of Unprown disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 ₹F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has birector, page 2 s autopsy death? 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify, Certificate: To I 1 Yes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA n 24 hours atter recomment he Funeral Director: After the noteted filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Sachder 8MD

Registrar DHMH 17 Rev 7/2009

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126 A, E Kigh St, Elh Jon MD 21921.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SACHDEN MD

31. Date filed (Month, Da

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 22382 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 19, 2010 **Physician** 8:45 РМ Barlow Mareen Johnston /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Glen Arm Glen Meadows 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/21/1915 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 1 □ M 2 🛛 F West Virginia 224-32-2500 95 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantinal must be notified at 1 ☐ Yes 2 No Director Glen Arm Baltimore Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21057 11630 Glen Arm Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: ģ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automobile Repair 12 Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Clark Hugh Granville Johnston ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1614 Samantha Drive, Forest Hill, Md. 21050 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any Injury or other trau Sarah Harris (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XX urial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 07/26/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Fuperal Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Conset and Death Imm late Cause (Final dise se or condition resulting in death) Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yeş 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Man or of Death 1 Vatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 □Yes 2 □No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M MM MAD CHANC WOOL N CHANGES 6701 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Year 16:50 PM Medical 2010 4b. City, Town, or Location of Death Examiner 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **∠**M 2 □ F Months Director Carolina show 10d. Inside City Limits 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director or 28a-f 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 23a Funeral "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 1. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2
If Yes, Give Completed by 1 Never Married 3 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ¹ ife. DO NO College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname 19a. informant's Name/Relationship (Type, Print)
Brendu Brown (19b. Mailing Address (Street 20b. Place of Disposition (Name of injury or Donation 5 Other (Specify) Signature of Eureral Service Lil ensee NO155 2d. Bal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cerebrovaniula Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) [/]Examiner Therosclushic Sequentially list conditions, Examine in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit nes le no lan Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): physician Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant a g 🗌 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Obesit Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has I page 2 performed 1 Yes 2 -140 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural injury 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpleted filled in by the fu 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29b. Signature and titl 29c. License number D 69540 M.D. 2010. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21234

Registrar

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31. Date filed (Month, Day, Year)

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words Rd Swife 204 Parkrille MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:23 AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE NORTHWEST RANDA 10 KM 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. ge (In **Funeral** Days Min. 213-14-983 M M 2 □ F Months Hours **Director** Usual Residence of Decedent 10a. State City Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No *baltimore* ndsor 10g. Citizen of What Country? 10e. Street and Number Funeral USA W00d 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BCompleted 3 Widowed 4 Divorced ack Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working lip. DO NOT use retred) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Mental Hygiene. narked other than /Seconday (0-12) College (1-4 or 5+) ayer Be (First, Middle, Last) Name (First, Middle 17. Fath are permit. Page 1 and 2 should Department of Health and MI Important: If item 27 is mar any injury or other traumati (Wite) Informant's Name/Relationship (Type, Print) 19b. Mailing Addr Harol Yal 20b. Place of Disposition (Name of City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) of Funeral Service License Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATYEROSCLEROTU Physician/ 1010 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes 25. Was case referred 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Nes မ 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. May er of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to the funeral part of th injury Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier 2010

Registrar

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Brown Month ennu ouis T: 00P M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner 3602 Kings Point Koad Randallstown Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F (Month, Day, 212.56.9589 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director MD Baltimore Kandallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 360 21133 KINGS 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. n "natural", or iten ledical Examiner n 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify: Black permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ravens Adult Elementary/Seconday (0-12) College (1-4 or 5+) COOK Center 10th grade Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. Brown Lari Nova Sauls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie D. Harper SISTER 3602 Kings Point Road Randallstown MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Baltimore, MD trbutus Cemetery 7/21/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee augm C. Greene Funtral Services 22. Name and Address of Facility Road Randall stown ND 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Physician Esophageal Cancer disease or condition resulting in death) 0 months Medical Due to (or as a consequence of): Examiner Alcoholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or, signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day Year Pregnant at time of death ☐ Yes ∠ ⊭ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , After this certificate has a funeral director, page 2 autopsy performed 2 🔀 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) Hospital 2 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 🗀 Pending 1 🔀 Natural work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide I Director; A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours of To the Funeral I Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) adolation Lavar 07-16-2010 259027 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lavanya Yarlagadda 2401 W. Belvedere Avenue Baltimore, MD 21215 31. Date filed (Month, Day, Year, 32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

cal	1. Decedent's Name (First, Middle, Las						2. Date of Dea	giene 20 (Reg. No. tth Day Zu / C	3. Time of Death		
ner	4a. Facility Name (if not institution, give Seasons Hospice at		t Hosp		•	or Location of Death 11stown		4c. County of Dea			
	5. Social Security Number 6. Se 214–40–5453		(In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV 18	g. B (Year) 1919 Mai	irthplace (State or Foreig ountry) ry Land		
tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	ation			<u>-</u>	10d. Inside City Limit		
Director	MD Baltim			lalls t	10f. Zip Code	Owings Mi		10 00 00	1 🗆 Yes 2 🔀 1		
Funeral	10e. Street and Number 9451 F 4511 Robbosson		Lane		21133	<u>-</u> 21117		10g. Citizen of What C USA	country?		
ò	11. Marital Status 1 □ X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates.		- If `		Hispanic Origin? (Spean, Mexican, Puerto Specify:		14. Race - Am Black, Whi Specify: b1	ite, etc.		
piere	15. Decedent's Ec (Specify only highest gra	ducation	16		nt's Usual Occup nd of work done	pation during most of work	ing	16b. Kind of Busines	s Industry		
Completed	Elementary/Seconday (0-12)	College (1-4 or 5+	-)		NOT use retired, cher)		educatio	n		
2	17. Father's Name (First, Middle, Last) William Henry Br	itt				18. Mother's Name	e (First, Middle, I etta Har				
	19a. Informant's Name/Relationship (Ty Patrice Williams		1!	9b. Mailing 9451	Address (Street	and Number or Rura	al Route Number,	; City or Town, State, Z S Mills, M	Zip Code) ID 21117		
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specifi	n state			tion (Name of atory or other pla		Date	20c. Location - City of	or Town, State		
	21. Signature of funeral Serviced icens	Valle, Wire	ctor			attiny ^{lity} Boar e, Marylar	•	W. Baltimo	re Street		
	23a. Par 1. Enter the disease, or comp shock, or heart failure. List only of immediate Gause (Final disease or condition	ne cause on each line.	elon	o not enter		ng, such as cardiac o			Approximate Interval Between Onset and Death		
1	Due to (or as a consequence of): Sequentially list conditions, b.										
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a	consequenc	e of):							
_ 1	that initiated events resulting in death) Last	Due to (or as a	consequence	e of):							
n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of death 1										
ıysicia	Part II. Other significant conditions co	ontributing to death but	t not resulting	g in the und	derlying cause g	iven in Part I.		bacco use contribute t	to the cause of death?		
þ											
þ								sy prior to med? death?	completion of cause of		
Completed by	25. Was case referred to medical examiner?	Ucenital:				lace of Death (Check	autop perfor 1 🗌 Yes	sy prior to med? death?	completion of cause of		
To Be Completed by	examiner? 1 ☐ Yes 2 ▼ No 27. Manner of Death	Hospital: 1 □ Inpatier 28a. Date of injury (Month, Day,	28b	Outpatient Time of injury	3 DOA Oth	ner: 4 ☐ Nursing Hory ry at k?	autop perfor 1 \(\sup \text{Yes}\) (only one)	sy prior to med? death?	os 2 No		
To Be Completed by	examiner? 1 ☐ Yes 2 🜠 No	1 ☐ Inpatier 28a. Date of injury (Month, Day,	Year) 28b	o. Time of injury	3 DOA Oth 28c. Inju wor 1	er: 4 Nursing Ho ry at k? Yes 2 No	autop perfor 1 Yes conly one) me 5 Reside 28d. Describe ho	prior to death? 2 No 1 Yes	o completion of cause of		
Medical Certificate: To Be Completed by Physician/Medica	examiner? 1	1 ☐ Inpatier 28a. Date of injury (Month, Day, 28e. Place of Injury building, etc.	Year) 28b Year) 28b y - At home, (Specify) ny knowledge amination and	farm, stree	3 DOA Oth 28c. Injunyor 1 Lt, factory, office cured at the time pation, in my opini	er: 4 Nursing Ho ry at k? Yes 2 No e, date and place, an on, death occurred at	autop perfor 1	prior to death? 2 No 1	o completion of cause of the second section of cause of the second section of cause of the second section of cause of the second section of cause of the second section of cause of the second section of cause of the second section of the second section of the second section of cause of the second section of cause of the second section of the section of the sect		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		-	For State Registrar	State of Ma	aryiano		tificate of D		and we			2010	22387
	Physicia	n /	1. Decedent's Name (First, Middle, La	st)					2.	Date of Deat Month		y Year	3. Time of Death
	Medic		Anna May Burgess							July	17		
	Examin	er	4a. Facility Name (if not institution, give				4b. City, Town, or		f Death			. County of Dea	
			2031 Holborn Road 5. Social Security Number 6.5		e (In yrs. las	t hirthday)	Dundalk If Under 1 Year		P4 Hrs. Ω	Date of Birth		Baltimo	rthplace (State or Foreign
H	Funeral Director			M 2 DXF 87	in yrs. ias	Yrs.	Months Days	Hours	Min.	(Month, Day, ug • 17	Year)	922 <u>Ma</u>	ryland
	at at	ō	10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits
	Aaryk 8a-f : tified	Director	Maryland Balti	more	Du	nda1k							1 🗆 Yes 2 💢 No
	the N	Ö	10e. Street and Number				10f. Zip Code			1	10g. Cit	tizen of What C	ountry?
	s 23,	Funeral	2031 Holborn Road	d			21222				Un	ited St	ates
	death riter ner n		11. Marital Status	12. Was Decedent E Armed Forces?		13. V If	Vas Decedent of Hi Yes, specify Cubar	spanic Origi n, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		14. Race - Ame Black, Whi	
36	e filed within 72 hours after death with the Maryland Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates,	No	1	☐ Yes 2 🔀 No	Specify:				Specify:	hite
ğ	hours natura ical E	lete	15. Decedent's I	Education	T	16a. Deced	ent's Usual Occupa	ation		- 1	16b. K	ind of Business	
21215-0036	in 72 e. nan "ı	Completed	(Specify only highest gaster) Elementary/Seconday (0-12)	rade completed) College (1-4 or 5	+)	(Give k life. DC	tind of work done d O NOT use retired)	luring most	of working				
2	ygien ygien her th	Be C	7 years			Homen	naker					wn Home	
Maryland	be filed ye ental Hygred rked oth	To B	17. Father's Name (First, Middle, Last)							irst, Middle, N		Surname)	
Ĕ	should b and Mer is mark raumatic		Robert Thompson 19a. Informant's Name/Relationship (Time Print)		40h Mailim	g Address (Street a			Mannin		Town State 7	in Cada)
≅	12 shouth and the and		Angela Oetting		htor		•				-		
യ്	and Hear	Ш	20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of		Date			ocation - City o	
Baltimore,	permit. Page 1 a Department of I Important: If it any injury or of		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	-A	A	cemetery Cemetery		/22/2	010	Bal	timore.	Maryland
altı	partit. P porta porta y inju		21. Signature of Fyleral Service Lice		1//	132	Name and Addres	s of Facility					
<u> </u>	8 2 E 6	1	(Mal	15/2 ps	W	179	122 Wise	Avenu	ıe Du	ndalk.	Ma	ryland	21222
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each line	the death.	Do not ente	r the mode of dying	g, such as c	cardiac or re	spiratory arre	st,		Approximate Interval Between
~ i	nysician/		Immediate Cause (Final disease or condition	De	ment	tra							Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
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ar	ted nsit	Examiner	frany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury			,							
	executed an and rial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):							
Ö	ficate be executed g physician and as the burial-transit	Completed by Physician/Medical		■ d									
8760	tificat ng ph as th	Mec	IF FEMALE:										
89 X	th cer ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Fetal	death 3 [Ectopic pregnanc	:y			1	23d. Date of do	elivery Day Year
Box	e dear the at hed fo	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5∟	Other (specify)					WOTET	Day Tour
P. O.	nat the ed by detac	/ Ph	Part II. Other significant conditions	contributing to death b	ut not resul	Iting in the u	nderlying cause giv	en in Part I.		23e. Did tob	oacco (use contribute t	o the cause of death?
S,	ires ti signi Id be	q p	Atrial	Pibrillati	en					1 🗆 Ye	es 2	□ No 3 □ I	Probably 4 Unknown
ord	v requ	olete								24a. Was ai			utopsy findings available
ec ec	he lav te has age 2	omp								autops perfori 1 Yes	med?	death?	completion of cause of
<u> </u>	an: T rtifica tor, p	Be C	25. Was case referred to medical				26. Pla	ace of Deatl	h <i>(Check on</i>		Z L/2 1 1	0 10 10	30 2 1110
=	hysica nis ce I direc	To E	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati		<u>`</u>	t 3 🗆 DOA Othe	er: 4 🗆 Nur	rsing Home	5 Reside	ence 6	6 ☐ Other (Spe	cify)
ō	ing Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of inju (Month, Day		28b. Time of injury	28c. Injury work	?	- 1	l. Describe ho	w injur	y occurred	
jo	ttend death tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not		ını At horr	no form etre		Yes 2 .		Looption (Ct	mat an	d Alumbar or D	ural Route Number,
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. Othe Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Cer	4 Homicide determined	building, etc		ie, iann, stre	et, lactory, office		281	City or Town			urar Houle Number,
	spital	ical		ysician: To the best of									
	ne Ho in 24 i	Medical		niner: On the basis of e rse Practioner: To the									cause(s) and manner stated. s stated.
	Vith To the	_	29b. Signature and title of certifier				29c. License			2	9d. Da	ite signed (Mon	
			Morron Konel	mu '	いか			2102	2			7-19-	/0
	2		30. Name and address of person who					177	X 21	12/			
	Stat	•	1. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	SLA IR	ne pro	MOM	1) 210	76			
	Registra		MU 202010 /	Enera D.	pa	Med							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per np 9905 7-23-10 yt State of Maryland Department of Health and Mental Hygiene 2010 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:15 N ^{Year} 201 July James Austin Barnhart 17, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Baltimore Lutherville If Under 1 Year Months Days Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F (Month, Day, Year) Nov 17 Hours 84 Country) Maryland Director 219-18-0555 1925 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21204 1 Acorn Hill Lane United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify 3 Widowed 4 Divorced Year or Dates. 1944 - 46 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Physical Therapist Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Edward Barnhart Alice Elizabeth Friedline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor M. Barnhart /Wife 1 Acorn Hill Lane Towson, MD 21204 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jul 1 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Etrysicidil disease or condition resulting in death) PARKINSON'S DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examiner Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last been signed by the attending physician and Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) Day Year 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) မ 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the f. 1 Yes 2 No Investigation Accident
Suicide
Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and **/d**d erson who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

JACKIE JONES,

31. Date filed (Month, Day, Year)

CRNP

2010

JAMES BARNHART

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

arks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 22389 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ July Helen Louise 15 Bungori 11:35 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2935 Shelly Court Abingdon Harford If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Days Hours Min (Month, Day, Year, West Virginia Director 216-30-5632 76 1934 Usual Residence of Decedent Show 10b. Count 10c. City, Town or Location 10d Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No Maryland Harford Abingdon 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2935 Shelly Court 21009 filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black White etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes Give Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filec.
Department of Health and Mental Hv.
Important: If item 27 is marial any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P William (NMN) Carr Bertha (NMN) Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma Mollor / Daughter 2935 Shelly Court, Abingdon, Maryland, 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdn. 7/20/2010 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Dartwasce 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final MEMSMANL CANCER Physician/ disease or condition resulting in death) Medical Due to (or as consequence of) Examiner SPO Sequentially list conditions, if any hading lown hading cause. Enter Underlying Cause (Disease or iinjury Examiner burial-tran that initiated events Due to (or as a consequence of) physician Physician/Medical Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the t signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPOLIGNSION 1 Yes 2 No 3 Probably 4 Unknown Records, Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? certificate Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medica completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident☐ Suicide Investigation Director 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 7/16/10 1/ men H40769

DHMH 17 Rev 7/2009

State Registrar 2227 OLD EMMORDIN RD STE ZZO BERAR MB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DoimElen

32. Registrar's Signature

m

GREGOM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 22390

1. Decedent's Name (First, Middle, Last)

John Whorley Bowling

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 22390

Certificate of Death

Month / Day Year 3:15 PM

Physician/ Medical Examiner

	Examin	er	CITIZENS	Vursing	g Hom	e Hau	re De	Grace	2 4c. County of Dea	rford
	Funeral Director		5. Social Security Number 6. Security Number 210–42–1942	x 7. Age (/	n yrs. last birthda 7 Yrs	Months Days	If Under 24 Hrs. Hours Min.		9. Bi y, Year, 24, 1952 M	rthplace (State or Foreign
		-	Usual Residence of Decedent		/			CCCCCC	24,1042 11	aryrand
	land show	ţŏ	10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
	Mary 28a-f otifie	irec	Maryland Harfor	rd	Aber	deen				1 Yes 2 □ No
	with the s 23a or ust be n	Funeral Director	10e. Street and Number 1 Franklin St. A	pt. 2		10f. Zip Code 2100	01		10g. Citizen of What C	ountry?
036	be filed within 72 hours after death with the Maryland ental Hygiene. **	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates.		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp an, Mexican, Puert		14. Race - Am Black, Whi Specify: Whi	te, etc.
Maryland 21215-0036	ithin 72 hour ene. • than "natu he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		1 (G	cedent's Usual Occup ive kind of work done (. DO NOT use retired) disabled	during most of wor	king	16b. Kind of Business	s Industry
and 2	l be filed wifental Hygin rked other tic event, t	To Be	17. Father's Name (First, Middle, Last)	<u> </u>		41545	18. Mother's Nar		Maiden Surname)	
ary	1 and 2 should be fi f Heatth and Menta item 27 is marked other traumatic ev		James Bowling 19a. Informant's Name/Relationship (7)	rpe, Print)	19b. N	ailing Address (Street			er, City or Town, State, Z	ip Code)
	d 2 sheath a		Pansy Doane (sis	ster)	80	Waterview	Way, Edg	ewood, N	4D 21040	
Baltimore,	o :: == 15		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		cemetery,	sposition (Name of crematory or other place	ce) 7/8/	Date	20c. Location - City o	
MI I	permit. Pag Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Specification of Lines Service)		Baker C	emetery 22. Name and Addre			Aberdeen,	
ñ	Imp any	e) l	1 Tro	mi		Aberdeen,	Marylan			l Home, P.A.
7	Pnysician/ Medical		23a. Part 1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the cause on each line. a	Civ	enter the mode of dyin	RIVOS	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions,	h						
	recuted and al-transit	Examiner	If any, leading to I minedate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a c						
9	certificate be executed inding physician and use as the burial-transif	edical	·	d						
. Box 68/60	death le atte ed for	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 Ectopic pregnant 5 Other (specify) _	су		23d. Date of d Month	elivery Day Year
л О	that the ined by the detache	by Pr	Part II. Other significant conditions of	ontributing to death but	not resulting in t	ne underlying cause gi	ven in Part I.	23e. Did t	obacco use contribute t	to the cause of death?
ds,	equires sen sig ould b		JANO WO	00121111				1 🗆		Probably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician; The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completed filled in by the funeral director, page 2 should be del	Completed							psy prior to ormed? prior to death?	utopsy findings available completion of cause of
ta	ician; certific ector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital:		Oth	lace of Death (Che	, ,		
× ×	Phys r this eral dii	e: 10	1 ☐ Yes 2 X No 27. Manner of Death	28a. Date of injury	t 2 ER/Outp	e of 28c. Injur	4 Nursing F y at	T	dence 6 Other (Spe how injury occurred	ecify)
UC C	ath. r: Afte	icat	1 Natural 5 Pending 2 Accident Investigation		<i>(ear)</i> inju		⟨? Yes 2 □ No			
INISIC	I or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm Spec <i>ify)</i>	street, factory, office		28f. Location (City or Tox	Street and Number or R vn, State)	ural Route Number,
	ne Hospita n 24 hours ne Funeral pleted filler	Medical	(Check 2 Medical Exam	ner: On the basis of exa	mination and/or ir	vestigation, in my opini	on, death occurred	at the time, date	ause(s) and manner as s and place, and due to the ne cause(s) and manner a	e cause(s) and manner stated.
	No the company of the		29b. Signature and title of certific	A. to	role 1	29c, Licens	p 428	00	29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who a	5 A-	9/6000	e, Print) (Bus ly	Wh !	tale, del	121078
	Stat Registra		31. Date filed (Month, Day, Year) JUL 2 0 201	3. Registrar's	Signature .	ared			1 .(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per M1,995 7/20/10 TT
State of Maryland / Department of Health and Mental Hygiene 0 | 0 22391 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Charles B. Rowman . Day 2010 Physician/ J_{u}^{Month} 15, harles 12:35a [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3328 Churchville Road Aberdeen Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🔀 M 2 🗆 F 1070671918 220-07-5002 **Director** Maryland 91 Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2XXNo Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3328 Churchville Road 21001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

No 1942-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 🏋 No Specify: Specify: White "natural" Completed 3XXWidowed 4 ☐ Divorced 1945 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) **Appliance** Repairman permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lonnie G. Bowman Agnes Bechtold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lonnie F. Bowman (son) 809 John Smith St., Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔯 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 7/19/10 Aberdeen, Maryland 21. Signature of Funeral Service Vensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Maryland 21001 Aberdeen, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Exami led by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 🔲 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) 235012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BelAir, and. 21dy 615 McPhail Rd. · Keria LANCH

DHMH 17 Rev 7/2009

54)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Please T	ype or Print in Blac	k Indelible Ink	Ensure All	Copies Ar	e Legible	
			Registrar	State of Maryland / D	epartment of He Certificate of De	ealth and Me eath	ntal Hygien		22392
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Timothy Campbel	1, Sr.			Date of Death Month Duly I	Oay Year	3. Time of Death
	Examir		4a. Facility Name (if not institution, give stre Sing) Hospital	· ·	4b. City, Town, or L			lc. County of Dea	th
= =	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs. 8. Hours Min.	Date of Birth	g. Bir	thplace (State or Foreign untry) Maryland
agn		'n	Usual Residence of Decedent 10a. State 10b. County	10c. City. Town	or Location ltimore		an. 19,	1908	10d. Inside City Limits
Cai	e Maryla r 28a-f s notified	Director	Maryland N/A 10e. Street and Number	Ва	10f. Zip Code		La		1y Yes 2 □ No
thy	h with th ns 23a o nust be	Funeral	5124 Arbutus Ave	nue	21215		t	Ditizen of What Co	ountry?
Timothy Campbell	rs after death ural", or iten		11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	13. Was Decedent of His If Yes, specify Cuban, 1 Yes 2 No		y Yes or No- an, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
Patient Known as Tur Baltimore, Maryland 21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	Decedent's Usual Occupat Give kind of work done du ife. DO NOT use retired) ofer	ion ring most of working	1	Kind of Business	-
Known Iryland 21	d be filed valental Hygarked otherit.	To Be	17. Father's Name (First, Middle, Last) Johnny Campbell,	Sr.		8. Mother's Name (F Lois Har		n Surname)	
Man,	nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Johnny Campbell,	Jr./Brother	Mailing Address <i>(Street an</i> 5124 Arbut	d Number or Rural Ro Lus Avenu	oute Number, City ie Balti	or Town, State, Zi Lmore , M	D 21215
atie imore	Page 1 ar ment of He ant: If iten ury or oth		20a. Method of Disposition 1	moval from State cemetery	Disposition (Name of crematory or other place) on Cemeter			Location - City or nsdowne	Town, State , Maryland
P ₁ Balt	permit. Depart Import any inj		21. Signature of Funer I sale in sale	aris	22. Name and Address				eral Home MD 21215
	Pnysician	~	23a. Part 1 Enter the disease, or complications, or heart failure. List only one of Immediate Cause (Final Isease or condition	cause on each line.	TRATORU	such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a consequence of MASSIVE A):				UNKNOWN
	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of CIRRHOS)):				
09	ath certificate be executed attending physician and for use as the burial-transit	<u></u>	that initiated events c. resulting in death) Last	Due to (or as a consequence of HEPATITI'S):				
. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici tted filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	livery Day Year
ds, P.O.	requires that the de- been signed by the s should be detached	by	Part II. Other significant conditions control COAGU WO PAT	0	the underlying cause give	n in Part I.			the cause of death?
Division of Vital Records,	The law recate has be page 2 sho	Completed					24a. Was an autopsy performed?	prior to	itopsy findings available completion of cause of
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hos	spital:	LOthor	e of Death (Check on		6 Other (Spec	cify)
n of	nding Ph tth. : After th e funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	28a. Date of injury (Month, Day, Year) 28b. Tii	ury work?		. Describe how inju		
Divisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farr building, etc. (Specify)			. Location (Street a City or Town, Stat		ral Route Number,
_	he Hospit in 24 hour he Funera	Medical	(Check 2 L Medical Examiner	an: To the best of my knowledge, do : On the basis of examination and/or ractioner: To the best of my knowle	investigation, in my opinion,	death occurred at the	time, date and place	ce, and due to the	cause(s) and manner stated.
	To t with To t		29b. Signature and title of certifier		29c. License r	umber (30		ate signed (Mont)	
			30. Name and address of person who com ANA € W1 WAWD	pleted cause of death (Item 23a) (Ty					
2	Star Registra	te ar_	31. Date filed (Month, Day, Year)	32. Registrar's Signature			, .		
✓ DH	IMH 17 Rev 7/20				IGINAL		_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 22393 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 01:30 a^M Tuly Daniel Myron Clark, Sr 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Co. Glen Burnie 106 Stevens Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1**X** X M 2 □ F Months Davs Hours Min. (Month, Day, Yea, 03/10/193 Country)
Maryland Director 78 212-30-1001 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Glen Burnie MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21060 United States 106 Stevens Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14 Race - American Indian. Armed Forces:

1 X Yes 2

If Yes, Give

Year or Dates. Black, White, etc. Š 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Korean war Specify: 3 ₩idowed 4 □ Divorced Completed White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter's Union Carpenter vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ၉ Estelle Lowman Myron Eugene Clark Hattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 R Lake Shore Drive Pasadena, MD Mrs. Cindy D. Clark-Reed/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place 1 🕅 Burial 2 🗌 Cremation 3 🔲 Removal from State 07/21/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Glen Haven Mem Park 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Ser 1 2nd Ave SW, Glen Burnie, MD 21061 M01121 Services, PA; 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Netastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death ed by the a Hnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ğ page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☐ ☐ o Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 5 Pending ours after death. leral Director: Af filled in by the fur 2 🗌 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, Homicide determined City or Town, State, 24 hours Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year, erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Colen Burnie MA 21001 Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Deced nt's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 p M Physician/ Month 2010 Medical 4a. Facility Name (*not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County, of Death are Luchearn timove al 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours 3 Director apolino Usual Residence of Decedent Show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No 10e. Street and Number 10f. Zip Code and 10g. Citizen of What Country? by Funeral 21234 lasant 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black. White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 13 lar 3 Widowed 4 Divorced Completed Year or Dates it of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Si ည hes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numbe 100 Department of Heam Important: If item 2 any injury or other 00 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Sign OK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cat liac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ XLavi disease or condition resulting in death) mont Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to humediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami use as the burial-transi physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death Yes s been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 sl performed Yes 2 within 24 hours after death.

To the Funeral Director. After this certificate completed filled in by the funeral director, pag 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gentlying Physician to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Number Practioner Texts a date of my more agest and counted at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature 29d. Date signed (Month, Day, Year) 29c License number address of person who completed cause of death (Item 23a) (Type, Print)

W. MENNITI 2835 SHITH AVE MALTIHOUT, UD 21209 SUITE 203 32. Regist av Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of M	laryland /	Depa Cer	artment of H tificate of D	lealth ar Death	nd Mental Hy	giene 20	10	22395
	Physicia		1. Decedent's Name (First, Middle, Last) Mary J. Conrades				2. Date of De Month			ath Year 3. Time of Death		
	Medic Examin		4a. Facility Name (if not institution, give street and number) Peninsula Regional Applicac Confu				4b. City, Town, or Location of Death			4c. County of Death Al Conico		
1	Funeral Director			/	ge (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da June 10	th		ace (State or Foreign
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loca							Od. Inside City Limits
9200		Funeral Director	MD Somer	Princess Anne				1 ☐ Yes 2 No 10g. Citizen of What Country?				
		ineral	26461 Bateau Lane			21853				USA		
		by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 12. Was Decedent Armed Forces? d 1 ☐ Yes 2X☐ If Yes, Give Year or Dates.		l I	Vas Decedent of His Yes, specify Cubar	n, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	Blac	ce - America ck, White, et . white	tc.
21215-0036		Completed	15. Decedent (Specify only highest Elementary/Seconday (0-12)					ation uring most o	f working	16b. Kind of Business Industry		
d 21		To Be Co	9 17. Father's Name (First, Middle, La.	0	<u> </u>	hou	sewife	18. Mother's	s Name (First, Middle.	OWn Maiden Surname		
Maryland			James Stanley N					Dori	s Mary Wal	ker	,	
			19a. Informant's Name/Relationship Stanley Bozman		r i	9b. Mailin 131	g Address (Street a 83 Hop F:	nd Number o isher	or Rural Route Numbe Lane; Prir	r, City or Town, S ncess An	itate, Zip Co ne,MI	D 21853
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other Sp			tery, crem	sition (Name of natory or other place		Date	20c. Location -		
Bal			1-110000	Wade Di	///	-	baltimor	e. Mar	Board; 65: cyland 212	Ul	timor	e Street
	Physician/ Medical		23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or conclines resulting in death) a. Bowel Is the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Due to (or as a consequence of):								Interval Between	
	I or Attending Physician: The law requires that the death certificate be executed after death. Director After this certificate has been signed by the attending physician and all in by the funeral director, page 2 should be detached for use as the burial-transit of	/Medical Examiner	Sequentially list conditions.	b. Melista	tu o	ran	ion can	anom	d			
			if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as	a consequence	e of):						
0			resulting in death) Last	Due to (or as	a consequence	e of):						
38760			IF FEMALE:	220 If you outcome	of prognancy.							
). Box 687		Physician/Me	23b. Was decedent pregnant in the past 12 pronths? 1 Yes No				Other (specify)			23d. Date of delivery Month Day Year		
ds, P.O.												
Recol		Completed by							24a. Was autop perfo 1 \(\sum \) Yes	osy rmed?		sy findings available pletion of cause of
Vital		To Be	25. Was case referred to medical examiner? 1 Yes V No									
n of			27. Manner of Death Natural 5 Pending	28a. Date of inju (Month, Da	ıry 28b	. Time of injury	28c. Injury work?	at	28d. Describe h	ow injury occurre		
Division of Vital Records,		Certificate:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determin	t be 28e. Place of Injury	28e. Place of Injury - At home, farm, streed building, etc. (Specify)					28f. Location (Street and Number or Rural Route Num City or Town, State)		Route Number,
		Medical	(Check 2 Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	examination and	or investi	gation, in my opinio	n, death occu	rred at the time, date a	nd place, and due	e to the caus	se(s) and manner stated.
			29b. Signature and title of certifier	~			29c. License			29d. Date signed		ay, Year)
			30. Name and address of person when Voltra	o completed cause of c	leath (Item 23a	SHUR	E BC, S	A LISB	URY, MD . 2	184		
	Stat Registra	-	31. Date filed (Month, Day, Year)	2 0 2010 (ar's Signature	1	bark		UF-4, ND, 2			
	1⊔ 17 Pov 7/20		AAP	- PAIA		-	11					

10-04883										
Michelle Cox										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Day June 29, 2010 **Medical Examiner** 1112 hrs Michelle Cox 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6912 Gough Street **Baltimore** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk 5. Social Security Number unk6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 1 M 2 F 58 Jan 22, 1952 Country) Yrs Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 No dother than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. hours after death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6912 Gough Street 21224 IISA Funeral 11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces? unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married White, etc. 2 "natural", or Yes Specify: White 4 Divorced If Yes, Give Year Yes 2 X No specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done UNK) 16b. Kind of Business/Industry UNK Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat injury or other trannatic event, the Medical Exp. Elementary/Secondary (0-12) College (1-4 or 5+ unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Unk. Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street; Baltimore, Maryland 21201 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Ronald rector rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician re. List only one cause on each line Between Onset and /Medical a Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical the attending physician and for use as the burial -UNPENDED AMENDED 23a, 27, PII, per ME g905 7/29/10 TT The law requires that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? P.O. ð Throat cancer 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, this certificate has been a director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 in 24 hours after one.

the Funeral Director: After this makety filled in by the funeral director. 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number June 30, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

OCME

Assistant Medical Examiner

32. Registrar's Signature

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygieney 22397 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month July 2010 10:50 PM Thomas Covle Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Oakcrest Village Nursing Home Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Nov 16, Year 925 Months Days Hours Min. Pennsylvania Director 84 125-14-9760 Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Parkville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8820 Walther Blvd; Apt 4122 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No 1944— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 1 Yes 2 No Specify: white 3 Widowed 4 Divorced 1945 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) federal government physicist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be Thomas F. Coyle Mary Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Walther Blvd; Parkville, Maryland 21234 Page 1 and 2 Marian Coyle - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other placel 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Service Licensee Ronald S, W. State Anatomy Board; 655 W. Baltimore Street Wade 2222 Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) END STAGE Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ◆ No 24a. Was an has autopsy performed? After this certificate To the Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitiying Nystaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. alexe moranee 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKVILL UD 21234 8800 32. Registrar Signature 31. Date filed (Month, Day, State

Registrar

9

HAWA!

10-05125 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Department of Health and Mental Hygiene John David Clemens 2010 22398 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 1830 hrs July 8, 2010 John David Clemens 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State or **Funeral** Months Days Hours Director Country) Mexico 07/20/1959 1 X M 2 F 50 214-78-8610 Usual Residence of Deceden any 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2X No or 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f shor r traumatic event, the Medical Examiner must be notified at once. Silver Spring Montgomery 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 20902 U.S.A. 11716 Lovejoy Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12 Was Decedent Ever in H.S. 14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2X No Yes 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: White þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. N/A 12 2 Disabled 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Hora John D. Clemens, Jr. Arlene M. Hopa 19a, Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (mother) 8656 Silver Lake Drive - Perry Hall, Arlene M. Clemens 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 X Burial 2 Cremation 3 Removal from State Ξ Joseph Church Cem 07/14/2010 | Baltimore, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Complications of diabetes mellitus Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical AMENDED 23a, PII, 27, per ME g905 7/29/10 TT X UNPENDED IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ē 1 Yes 2 No 3 Probably 4 🗸 Unknown Hypertensive atherosclerotic cardiovascular disease Completed page 2 should been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed 1 🗸 Yes Yes 2 No this certificate

Division of Vital Records, P.O. Box 68760, death.

> 30. Name and address of person who completed cause of death (Item 23a) State Registrar

DHMH 17 Rev 1/2001

OCME 2006

Be

Medical

After

Director: d in by the f

31. Date filed (Month, Day, Year)

Draine

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

(Specify)

and manner stated

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 No

Other Nursing Home 5 Residence 6 Other

or Town, State)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City

July 9, 2010

29d. Date signed (Month, Day, Year)

25. Was case referred to medical

29b. Signature and title of certifier

Melissa Brassell, MD

2 No

5 Pending

6 | Could not be

Investigation

determined

examiner?

1 X Natural

29a. Certifier 1

2

one)

3

1 Yes

27. Manner of Death

Accident

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22399 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 2010 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 000 more 7. Age (In yrs. last birthdav) **Funeral** Social Security Number 219-10-5854 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □**X**M 2 □ F Days Hours Min. Country) 0871371917 92 Director MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examinar must be a second 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE, #313 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5** DENTIST MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည FANNIE SAMUEL CHMAR PARKUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOLLIE CHMAR/WIFE 725 MT. WILSON LANE, #313, BALTIMORE, MD 20a. Method of Disposition 20b. Place Fisher Mily and of AITZ 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State CHAIM CEMETERY 7/18/2010 BALTIMORE, MD Donation 5 DOther (Specify) of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ trac disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, No. မ 1 Yes 1 Inpatient 2 €R/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 15.2010 of person who completed cause of death (Item 23a) (Type, Print) NW ED 5401 Old Courd Rd Randall stown Son A York

DHMH 17 Rev 7/2009

Registrar

32. Registrar's signature

for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Davs 214-18-2735 88 0670871922 Director MD Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits be notified at Director 28a-f BALTIMORE BALTIMORE 1 - Yes 2 1 No 10e. Street and Number 10f. Zip Code 21208 10g. Citizen of What Country? Funeral 3800 OLD COURT ROAD 21209 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 XNo If Yes, Give 1 ☐ Yes 2 ☐XNo Specify. WHITE 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **EXLER** DVORAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA MIRVIS/DAUGHTER 312 BRAEBURN GLEN COURT, MILLERSVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY ! 7/16/2010 BALTIMORE, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complicity in a that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on ear Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) umm Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live as a live of death Dinknown in the past 12 months? Month Yes 2 No 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗆 No Yes 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No Other: 2 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

filed (Month, Day,

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of M	laryland	l / Depa <i>Cer</i>	artment of F tificate of E	lealth and Death	Mental Hy	giene Reg. No.	010	22401
Physici Medi		Decedent's Name (First, Middle, LEUGENE WILLIAM	ast) CARR					2. Date of De Julu 19	Day	Year	3. Time of Death 4:10A M
Exami		4a. Facility Name (if not institution, git 3435 Ash Street	ve street and number)			4b. City, Town, or Baltim				ounty of Death	,
Funeral Director			Sex 7. Ag	ge (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th 3 <i>y, Year)</i> 1934	9. Birth	place (State or Foreign
and show lat	or	Usual Residence of Decedent 10a. State 10b. County			Town or Loc	ation	1 1	magase 7	, 1551		10d. Inside City Limits
ne Maryla or 28a-f notifiec	Funeral Director	Maryland None		Balti	more	10f. Zip Code			10g Citizo	en of What Cour	1XX Yes 2 □ No
th with the ms 23a c	neral	3435 Ash Street				2121			US	SA	
ife, Maryland Z IZ IS-DU30 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	<u>ک</u>	11. Marital Status 1 □ Never Married 2 □ Married 3 XXWidowed 4 □ Divorced	12. Was Decedent Armed Forces? 1		a I If	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 XX No	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		Black, White, becify:	
. 13-UU36 72 hours after n "natural", o Aedical Exam	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give k	ent's Usual Occupa ind of work done of NOT use retired)		orking	16b. Kind	d of Business Inc	
d within dygiene. ther tha nt, the N	Be Cor	Elementary/Seconday (0-12) 8 17. Father's Name (First, Middle, Lasi	College (1-4 or	5+)		chinist				eral Mach	ine Shop
Maryland Z Z I Z Should be filed within 7: and Mental Hygiene. I is marked other than raumatic event, the Me	To	Willie Summerfield					Bulah Car	rr (First, Middle,	Maiden Sui	rname)	
e, Mar and 2 shou Health and tem 27 is m	Ý	19a. Informant's Name/Relationship April Gordon	(Type, Print) Gr-Dt	r	19b. Mailin 3435 As	g Address <i>(Street &</i> Sh St ree t B	and Number or Ri altimore,	ural Route Numbe Maryland	21211 To	wn, State, Zip (Code)
DailIIIIOre, r permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1		20a. Method of Disposition 1 XXBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐ Removal from State	20b. Placen Parkw	ce of Dispos netery, crem nood Cer	sition (Name of atory or other place netery	July	Date 22, 2010	l	ation - City or To	
Daittinor permit. Page 1 Department of Important: If it any injury or o	100	21 gnature of Funeral Secretice	m Kena	Kes	22.	Name and Addres		tchell-Wie ad Baltimo			
Distriction (23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	mplications that cause one cause on each lin	d the death. e.	Do not ente				rest,		Approximate Interval Between Onset and Death
Physician/ Medical Examiner		disease or condition resulting in death)	a. Due to (or as	a consequer	nce of)	While	Ceino	ACY			2008
₽ .=	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	consequer	nce of):					- 6	20081
rate be executed rate by physician and street transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):						
ficate be g physici as the bu	Jedical		d								
The Hospital or Attending Physician: The law requires that the death certificinin 24 hours after death. The Foursa after death. The Funeral Director, After this certificate has been signed by the attending properties of the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	death 3 🗌	Ectopic pregnance Other (specify)	у		230	d. Date of delive Month	ery Day Year
requires that the de been signed by the should be detached	by	Part II. Other significant conditions Dir Stella ha									ne cause of death?
aw requires as been sig 2 should b	Completed	postopni c callop	re of (R)	lung	· a	lso ha	d	24a. Was	an 2	24b. Were autor	psy findings available mpletion of cause of
Physician: The law in this certificate has be are director, page 2 s		Laungell 25. Was case referred to medical	cancer				ace of Death (Che	perfo	ormed? 2 No	death?	·
Physicia This cert	: To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 lnpati 28a. Date of inju	ient 2 🗆 EF	R/Outpatient	LOthe	r: 4 Nursing I	Home 5 Resid)
tending Ph death. tor: After thi	Certificate:	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	on (Month, Da	y, Year)	injury	M 1	Yes 2 No				
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fun		4 Homicide determine	d 28e. Place of Injuiding, et	c. (Specify)				City or Tow	in, State)	lumber or Rural	
he Hosp in 24 hou he Funer pleted fil	Medical	(Check 2 L Medical Exam	ysician: To the best of niner: On the basis of e irse Practioner: To the	xamination a	nd/or investi	gation, in my opinio	n, death occurred	at the time, date a	ind place, an	nd due to the cau	use(s) and manner stated.
To t with To t		29b. Signature and title of certifier Muygu	who me	una	11110	29c. License			29d. Date s	signed (Month, E	Day, Year)
		30. Name and address of person who Marguerite Moran 200	completed cause of c	leath (Item 23	3a) (Type, Pr	int)			//	1-1110	
Sta Registra	te ar	31. Date filed (Month, Day, Year) 2									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 10 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:15 PM Constance Marian Davis Jul 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Date of bill. (Month, Day, Yea Mar 24 **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min Country) Maryland Director 193þ 217-26-8715 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Singer Road 21009 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2 🗙 No Specify: If Yes, Give Year or Dates Specify. 3 ▼Widowed 4 □ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Troutner James Thompson Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Davis /Daughter 504 Macintosh Circle Joppa, MD 21085 20b. Place of Disposition (Name of Date Jul 20c Location - City or Town State ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility MO1585 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Breast Capcer** Interval Between Ors, t and Deut Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA WSNIC Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Of D Natural 28d. Describe how injury occurred 5 Pending work М 1 Yes 2 🗌 No Accident
Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours a within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) He knowni 8

State Registrar

32. Registra 's Signature

6701

16252 Cd 1 405 MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	For State Registrar	State of Mary	yland / Depa <i>Cer</i> i	rtment of H tificate of D	ealth and I eath		giene 20 I	0 22403
	Physicia		1. Decedent's Name (First, Middle, Last	Dorda				2. Date of Dea Month	Day Y	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s			4b. City, Town, or I			4c. County of	70
	Funeral		1101 St. Paul S 5. Social Security Number 6. Secur	_	t1910 r yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	N/A	J. Birthplace (State or Foreign
	Director		213-00-0724	S	50 Yrs.	Months Days	Hours Min.	0 7724		laryland
	and show 1 at	ō	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Loc	ation				10d. Inside City Limits
	Maryl 28a-f notifie	Director		/A	Ba	ltimore				1 🛣 Yes 2 □ No
	vith the 23a or st be r		10e. Street and Number 1101 St. Paul S	troot uni	+ 1010	10f. Zip Code 21 2 0 2)		10g. Citizen of Wha	
	death v items ner mu	Funeral		12. Was Decedent Ever Armed Forces?	in U.S. 13. W	as Decedent of His Yes, specify Cuban	panic Origin? (Sp	ecify Yes or No-		American Indian,
36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1 Never Married 2 XMarried 3 Widowed 4 Divorced	1 Yes 2X No If Yes, Give Year or Dates.	1 _	Yes 2 XNo		Tricari, cic.,		White, etc. Black
2-0	2 hours "natur edical I	Completed	15. Decedent's Edi (Specify only highest grad	ucation		ent's Usual Occupat ind of work done du		king	16b. Kind of Busin	
72	rithin 7: iene. r than the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5+) years	life. DO	NOT use retired)	mig mode or wan	w/ig	Mortga	re Co
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)	years	, ban		18. Mother's Nam	ne (First, Middle, I		ge co.
ryla	ould be d Ment marke natic	오	unk	D: #			Artinas			
	s 1 and 2 should be filed withi of Health and Mental Hygien of item 27 is marked other th r other traumatic event, the		19a. Informant's Name/Relationship (Typ. Brianna S. Dark	. ,		Address (Street ar			-	e, Zip Code) to., MD21202
ore,	ge 1 and to fit of He it of He or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 I	2	20b. Place of Dispos	ition (Name of	i	Date	20c. Location - Cit	
Baltimore,	Pag nen ant:		4 ☐ Dopation 5 ☐ Other (Specify) 21. Sig (1) e of Fun ral Service (1) use	-	Joseph Crem				Baltimo:	
Ba	permit. Departr Importa any inji		21. Sig	1An	ਹੈ 21	osepni 40 N. Fi	Brown ulton A	Hr. FU	neral He ltimore	ome PA. MD 21217
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only one	e cause on each line.					est,	Approximate Interval Between
_ 1	Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	onsequence of):	lym	phone	7		nset and Death
	Examiner	.	Sequentially list conditions,). 			<u> </u>			
	ted 	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a co	insequence of):					
	ate be executed ohysician and the burial-transit	EX3	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
09/	cate be physic s the bu	edical	•	i						
/80 X	certificate ending phys	an/M	200. Was decedent pregnant	3c. If yes, outcome of p	regnancy Fetal death 3	Ectopic pregnancy			23d. Date o	of delivery
. Box	v requires that the death certifics been signed by the attending p should be detached for use as t	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at tim 9 Unknown		Other (specify)		7	Month	Day Year
7. O	s that t gned b be deta	þ	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the un	derlying cause give	n in Part I.			te to the cause of death?
ords	require been si should	eted						1 Y	/\	☐ Probably 4 ☐ Unknown e autopsy findings available
Vital Records,	he law te has age 2 a	Completed						24a. Was ai autops perfori 1 \(\sum \) Yes	ned? prior	r to completion of cause of
<u> </u>	ician: Tertifice	Be	25. Was case referred to medical examiner?	ospital:			e of Death (Chec	_	12 401	TIES ZLINO
> TO	g Phys er this eral dir	e: To	1 ☐ Yes 2 No 27, Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outpatient 28b. Time of	28c. Injury a	4 ☐ Nursing Ho	ome 5 Reside	nce 6 Other (S	Specify)
IVISION OF	tending leath. cor: Afte the fun	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Yea	ear) injury	M 1 □ Y	es 2 🗆 No			
SINIC	al or At safter of I Direct d in by		4 Homicide determined	28e. Place of Injury - building, etc. (Sp		t, factory, office		28f. Location (St. City or Town		r Rural Route Number,
 :	To the Hospital or Attending Physician: The law requires that the within 24 hours do Attending Physician: To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 L Medical Examine		ination and/or investig	ation, in my opinion	, death occurred a	t the time, date an	d place, and due to	the cause(s) and manner stated.
:	To the within To the compl		only one) 3 ☐ Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best	or my knowledge, de	29c. License r			gd. Date signed (M	
							2477		7/19	1/2010
			30. Name and address of person who co	opon,	22 3.	Greene	St.,	Balti	more,	MD 21201
F	Stat Registra	.	31. Date filed (Month, Day, Year)	32. Registrar's S		rackel				

DHMH 17 Rev 7/2009

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			For State Registrar	State of M		d / Depa		lealth and N	/lental Hy		2010		04
Phys M	iciar edic		1. Decedent's Name (First, Middle SHIRLEY ELIZ	, Last) ZABETH DAVI	S				2. Date of Dea July	ath	3, 20 ° 0	3. Time of Dec 3:05	ath a. M
	mine		4a. Facility Name (if not institution, 9010 Briarcroft		117		4b. City, Town, or Laure	Location of Death			County of Dea	th George's	
Fune Direc	_		5. Social Security Number 216-22-1208 Usual Residence of Decedent	1 M 2 878E	e (In yrs. la Bl	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jan • 29		9. Bir Co	thplace (State or Fountry) MD	reign
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. red define than "natural", or items 23a or 28a-f show it a supart the Macifical Examinar must be notified at		by Funeral Director	10a. State 10b. County	12. Was Decedent I	La 117	y, Town or Loc urel	10f. Zip Code 20708	} spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	_	tizen of What Co S • A • 14. Race - Ame Black, Whit	erican Indian,	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 77 is marked other than "natural", or		Completed	3 ☑️▼Vidowed 4 ☐ Divorced			16a. Deced (Give H	lent's Usual Occup kind of work done of NOT use retired) emaker		ing		Specify: Williams Wind of Business Wind Home	Thite Industry	
Maryland : should be filed v and Mental Hyg 7 is marked othe		To Be	17. Father's Name (First, Middle, L Oscar Snowden S	<i>'</i>				18. Mother's Nam Katheri			Surname)		
			19a. Informant's Name/Relationsh Michael S. Tate 20a. Method of Disposition		20h B	5313		ok Drive	Freder	ick,	Maryla	ind 21703	
baltimore, permit. Page 1 and Department of Hea Important: If item	o		Burial 2 Cremation 4 Donation 5 Other (S 21. Signature of Euperal Service L	Specify)	L C	emetery, crem estlaw	natory or other place in Mem Ga:	dens 7/2	1	Ма	ocation - City or	sville, MI)
Den Je	ouc o		1 G Str	/ MO(770	3	13 Talbo	rune t Avenue	Laure	1,Ma	ryland	20707	
Physicia Medi Examir	cal		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	only one cause on each line Cerebra a. Due to (or as a	al Th	rombos		g, such as cardiac c	or respiratory arr	est,		Approximate Interval Betwee Onset and Deat III Huces	n :h
be executed sician and burial-transit		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Metasta Due to (or as a Carcino C. Due to (or as a	a consequ	ence of): olon	oma					months	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicomplete filled in by the funeral director, page 2 should be detached for use as the		Completed by Physician/Med	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3 🗌	Ectopic pregnand Other (specify)	у			23d. Date of de Month	livery Day Year	
LS, P.O. Luires that the signed by all doe detail	:	ed by PI	Part II. Other significant condition Aortic Valve Pr		ut not resu	ulting in the u	nderlying cause giv	en in Part I.				the cause of death	
The law requires ate has been signage 2 should b		complet							24a. Was a autop perfor	sy rmed?	prior to death?	topsy findings avail completion of cause s 2 🛛 🛣	
VICAL /sician: s certific			25. Was case referred to medical examiner? 1 Yes 2 X No	Hospital:	ont 2 🗆	ER/Outpatien	Otho	ace of Death (Check	only one)			26.4	
Attending Phy r death. ctor; After this by the funeral control of the funeral control of the funeral control c			27. Manner of Death 1 XX Natural 5 ☐ Pending 2 ☐ Accident Investig	28a. Date of inju (Month, Day	ry	28b. Time of injury	28c. Injury work	at	28d. Describe h			<u> </u>	
tal or Atte		al Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi				et, factory, office		28f. Location (S City or Tow			ral Route Number,	
the Hosp thin 24 hou the Funer		Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of examiner: On the basis of examiner: To the Nurse Practioner: To the	xamination	and/or invest	igation, in my opinio leath occurred at the	n, death occurred at time, date and place	the time, date are, and due to the	nd place cause(s	, and due to the o s) and manner as	cause(s) and manner stated.	stated.
			29b. Signature and title of certifier	A Wane	~		29c. License			Ju	te signed (Monti	2010	
3			30. Name and address of person w William A War	ren, M.D.	321 P	rince	rint) George S	treet La	urel, M	aryl	Land 20	707	
	State		31. Date filed (Month, Day, Year)	General 32. Registy	r's Signati	ye Alas							

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State of Maryland / Department of Health and Mental Hygiene 20 10 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year 14:50 PM Baby Girl Dorsey 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKINS Hospital Baltimore donns If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** July 8, 2010 1 🗆 M 2 🕱 F Days Mary Land Director Yrs INFANT Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director Baltimore 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA within 72 hours after death with 21224 903 Coppin Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married black 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+)
INFANT Elementary/Seconday (0-12) INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I ပ should be Derek Harvey Dawtiera Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 903 Coppin Court; Baltimore, Maryland 21224 Dawtiera Dorsey - mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in State ROHALD S. Wade ^{22. Name and Address of Facility} Board; 655 W. Baltimore Street Darector Raltimore, Maryland 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Interval Between Onset and Death Physician/ Prematurity disease or condition resulting in death) Extreme Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 4 Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ₽ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 1 Tes 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 P.O. Records, of Vital Division

Maryland 21215-0036

Baltimore,

		3.17 4.1	- Large
(Check 2 Me	rtifying Physician: To the best of my knowledge, death occuredical Examiner: On the basis of examination and/or investigat rtifying Nurse Practioner: To the best of my knowledge, deat	tion, in my opinion, death occurred at the time, dat	te and place, and due to the cause(s) and manner state
29b. Signature and title of o	certifier	29c. License number	29d. Date signed (Month, Day, Year)

Regime McCartan CNA ROLLO85 07/08/2010
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

North Wolfe Street Baltimore MD 21287

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_			For State Registrar	State of Ma	rylariu		tificate of L		and we	eniai my	gieri Reg. N	2010	22406
	Physici	an/	1. Decedent's Name (First, Middle, La						2	2. Date of Dea Month		ay Year	3, Time of Death
	Medi	cal	Catherine Marie 4a. Facility Name (if not institution, give			-				July 1		2010	3:46 P M
	Exami	ner	, ,	,	'onto:	_	4b. City, Town, o Bel Ai		of Death		4	c. County of Deat Harford	
	Funeral	_	Upper Chesapeak 5. Social Security Number 6.		(In yrs. last		If Under 1 Year	If Under	24 Hrs. 8	3. Date of Birt	.h	9 Bir	thplace (State or Foreign
	Director		219-10-3190 Usual Residence of Decedent	1 □ M 2 X F	90	Yrs.	Months Days	Hours	Min.	(Month, Day 18	y, Year) B	1920 Pen	nsylvania
	ind Z 1 Z 1 Z 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ģ	10a. State 10b. County		10c. City, 1	Town or Loc	ation						10d. Inside City Limits
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	th the 3a or the r		10e. Street and Number				10f. Zip Code					Citizen of What Co	ountry?
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**	er de	by Fi	1 Never Married 2 Married	Armed Forces?		IS. V	as Decedent of H Yes, specify Cuba	ın, Mexicai	n, Puerto Ric	can, etc.)		14. Race - Ame Black, White	
25	rs afte	l pa	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1	Yes 2 🛭 No	Specify.	:			Specify: W.	hite
7	2 hour	blet	15. Decedent's (Specify only highest g			16a. Deced	ent's Usual Occup	ation	t of working		16b.	Kind of Business	Industry
01015_0026	within 72 hours after death with the Manyland glene. ier than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+))	life. DC	NOT use retired)	ioning in oc	it of Working			Shoo Man	ufacturing
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3451 :	J de file Mental narked c	[2	Ralph (unk) Bur							arie So		,	
15	s mar		19a. Informant's Name/Relationship (19b. Mailine	g Address (Street						Code)
	id 2 sl salth a n 27 is		George P. Beard	h / Son	T		Springda						
TOD	of He of He country		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 [Bamayal from State	20b. Plac	ce of Dispos	ition (Name of atory or other place	e)	Dat	te	20c. l	Location - City or	Town, State
, ,	Page ment tant:		4 Donation 5 Other (Spec	ify)			emorial C		7/19/	2010	Ε	Bel Air,	Maryland
O TOD	permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic ever once.		21. Signature of Funeral Service Licer	utwasci		22.	Name and Address					eral Hom	•
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三	Medical		disease or condition resulting in death)	Due to (or as a c			ic arr	237			-		-
7	Examiner	L	Sequentially list conditions,	h		Acut	e mupce	ardia	(in	faret	JOV	1	
7	· p #	nje	if any, leading to immediate cause. Enter Underlying	Due to (or as a c	on Sequen	ico UI).							
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2	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live Birth 2			Ectopic pregnanc	N/				23d. Date of del	Ivery
Box .	death	sicis	in the past 12 months? 1 Yes 2 No	4 Pregnant at ti	ime of dea	th 5	Other (specify)	У				Month	Day Year
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therine f	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Completed by Physician/Medical Examiner								autop perfor 1 \(\sum \) Yes	SV	prior to d	completion of cause of
a le	ian: T	Be C	25. Was case referred to medical examiner?				26. Pla	ace of Dea	th (Check or		2 15 1	io i les	2 2 110
于 5	hysic his ce	욘	1 ☐ Yes 2 ☐ No	Hospital: 1 1 Inpatient			3 🗆 DOA Othe	er: 4 🗆 Nu	ursing Home	5 🗌 Resid	ence	6 Dother (Spec	ify)
Cat	nding P tth. : After t	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,)		Bb. Time of injury	28c. Injury work M 1 🗆		.	d. Describe ho	ow inju	ry occurred	
Four, Division	Atter er dea ector by the	ertifi	3 Suicide 6 Could not l	28e. Place of Injury	- At home	e, farm, stree			_			nd Number or Rui	ral Route Number,
É CO	ital or Irs aftural Dir	a Ce		building, etc. (_			City or Tow			
Dafour	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical Exam	rsician: To the best of my niner: On the basis of exar rse Practioner: To the be	mination ar	nd/or investi	gation, in my opinic	n, death oo	ccurred at the	e time, date ar	nd place	e, and due to the o	cause(s) and manner stated.
	Noth Voith Com		29b. Signature and title of certifier	0			29c. License			. 1		ate signed (Month	
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_	8		30. Name and address of person who S. Zubair k	completed cause of dear	th (Item 23	3a) (Type, Pr	int) Aper Ch	esap	reake	Dr. B.	el	Air, MO	21015-
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Clinton Joseph Dick, Sr. 20°10 3:25 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2107 Cameron Court Bel Air Harford 5. Social Security Number 6. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, July 16 Director 219-32-9917 74 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Harford Air 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2107 Cameron Court Bel Air USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 ☐ Never Married 2 🔀 Married Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: "natural", Specify: White 3 Divorced 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 10 Owner / Operator Painting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Burton Dick Anna Marie Eckholm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra J. Dick / Wife 2107 Cameron Court, Bel Air, Maryland, 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 【 Other (Specify Entombment Bel Air Memorial Gdn: 7/17/2010 Bel Air, Maryland Signature Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a conse week e of): Examiner Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transi Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be execute physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g 🗌 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autops 1 Yes 2 No No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\overline{\chi}\) Residence 6 \(\sum \) Other (Specify) Hospital: မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred iniury Natural 5 Pending s after death 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number D5484 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Ashkan Bahrani,
31. Date filed (Month, Day, Year)

20

32. Registrar's Signature

602 S. Atwood Road, Suite 200, Bel Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per dr., g905,07/20/20I0dhb
Certificate of Death
Reg. NO Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) Examiner eh 11ton If Under 1 Year Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 ☐ M 2 🔯 F Georgia 89 577-24-5787 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Clinton MD Prince Georges Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 USA 9211 Stuart Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 🖾 No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife own home unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be ျှ 19a. Informant's Name/Relationship_(Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15033 Travert Way; Silver Spring, Maryland 20906 Spencer Drakeford - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State □Cremation 3 □Removal from State 5 ☑ Other (*Specify*) in state 1 ☐ Burial 2 ☐ Cremation 4 □ Donation 21. Signature of Funeral Service Licensee Nay Yor 22. State Address of Facility Board; 655 W. Baltimore Street 1/ay6 Baltimore, Maryland 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequal ce of Examiner Sequentially list conditions, if any local set 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by Common Arteri Diease

Division or Vital Records, To the Hospital or Attending Physician: nours after death.

neral Director: After this
filled in by the funeral di

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		24a. Was an autopsy findings availab prior to completion of cause or death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 🏖 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	(Month, Day Year) Injury Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month Day, Year) 29b. Signature and title of cert

pleted cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. for State Registrar 22409 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner MD. Mid. Center niversitu Of Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1271171933 Virginia Director 256-62-7815 76 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Harford Aberdeen 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with USA 712 Clayton St 21001 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No
If Yes, Give 1952-19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White, etc. or i Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1952–1973 Year or Dates. 1 Yes 2 No Specify. Specify: Afro American d Mental Hygiene. marked other than "natural", 3 X Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Military US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H ပ pe t Eddie Davis Susie Wormack permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Clayton St., Aberdeen, MD 21001 <u> William T. Davis (son)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gardens 7/23/10 Aberdeen, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Tarrin-Cargo Funeral Home, P.A. Maryland 21001 Aberdeen, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one Immediate Cause (Final Onset and Death √Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, 1 Yes 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 ☑ No certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA after death.

Director: After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending hin 24 hours after death. (Month, Day, Year) Natural 5 🗌 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficient of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0066995 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

A DED SY IN A
31. Date filed (Month, Day, Year)

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22 SIGREENE STREET BALTIMORE, MD 21201

AKINTIDE, MD.

32. Bajistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 2010 07:18 A M Physician/ JULY Medical 4c. County of Death Name (if not institution, give street and nun 4b. City, Town, or Location of Death Examiner Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs **Funeral** Months 1 **№** M 2 □ F Director 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a -f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ■ Yes 2 □ No þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden 2 rmant's Name/Relationship (Type, Print) Smallwood 2012 . Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 22-10 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastro intestinal Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24a. Was an Were autopsy findings available autopsy performed prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes To the Hospital or Attending Physician; 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🗌 No 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 🔲 Natural 5 Pending work? 2 🗌 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 29c. License number - Alsouro JULY, 16,201 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) manga am, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 20

DHMH 17 Rev 7/2009

Registrar

EYLER, SARAH JANE

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			For State			State	of Ma	rylan			ent of I ate of L		and M	lental Hy	/gien	е		
			Registrar 1. Decedent's Name	e (First, Middle	, Last)					erunca	ile or i	Jeain	Т	2. Date of D	Reg. N	<u>~20</u>	10	3. Time of Death
	Physicia Media		Sarah	Jan	ne	Ey	ler							JULY		ay	Year 2010	9:40 P M
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Division of Vital Records, P.O.	To the hospital or Attending Priysician: the law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the by	ed by	Part II. Other signific	zant condition	nis contr	ibuting to t	Jean Dui	not rest	alung in the	underlyin	g cause giv	en in Paπ						ne cause of death?
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۵ :	hours a	Medical (29a. Certifier 1	Certifying	Physicia	an: To the b	est of my	/ knowle	edge, death	occured a	at the time,	date and	place, and	due to the ca	use(s) a	nd manne	r as state	d.
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			30. Name/and address	V -1.	ho com	. "/	se of deat	h (Item :	23a) (Type,	Print) Z	Drive	0, (Glen	Bu	rni	e, 1	MD	21061
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death ent's Name (First, 2. Date of Death Physician/ 9450n w 2010 Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death venue Jai 8. Date of Birth Month, Day Age (In yrs. last birthday **Funeral** Birthplace (State or Foreign Country) Months Director or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or pother traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Midowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) econday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb Patricia Ferguson (Daughter) 608 Glenolden Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 D Other (Specify) saltimore 21. Signature of Funeral Service Licensee 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Day Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaçco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 No 2 🗆 No 1 \square Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specific 27. Manne of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D2653

Registrar
DHMH 17 Rev 7/2009

State

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

100 /00

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 22413 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harriet Ann Fintzell July 2010 $8:05P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 654 Cog Court Millersville Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept. 1 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 F Days 83 Yrs 1926 Nebraska Director 507-26-3864 Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any hipry or other traumatic events. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😾 No Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 654 Cog Ct. 21108 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: White Completed 3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Data Entry Data Entry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gould. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 654 Cog Ct. Millersville, MD 21108 Barbara Neff/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory Glen Burnie, MD 2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility SIngleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebrovascular Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗌 No 1 X Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Matural Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an**∩**itle of certifier 29d. Date signed (Month, Day, Year) July 15 D51596 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Dalewood a len Burnie MD 21061 K. Ambulavanor Risad 31. Date filed (Month, Day, 32. Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22414 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day Year **Physician** July 14, 2010 12:55 P M Fowler Margaret Williamson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Broadmead Cockeysville Baltimore f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗶 F Yrs. Director 87 217-20-9196 Jan 30, 1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show 1 ☐ Yes 2 No Director Cockeysville Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number Funeral 13801 York Road 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 ☑ No <u>م</u> Specify: Specify: 3 ₩ Widowed 4 Divorced "natural" White Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 5+ Editor Literature 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မှ Harold Williamson Virginia Alcock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7320 Meadow Lane, Chevy Chase, MD Pamela Leighton Fowler/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of H Important: If ite any Injury or ott once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 15 ☐ Other (Specify) Atlantic Crematory 7/16/10 Glen Burnie, Maryland 21. Single of Fun Service Licens 6

Bryan W. Clary 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc
10 W. Padonia Road, Timonium, Maryland 2 23a. Part 1. F ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, r heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca : 4º nal disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Day 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 D No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Records, of Vital Division

the Maryland

should be filed within 72 hours after death

Pages 1

altimore, Maryland 21215-0036

Legas L Hospital or Attending within 24 hours a To the Funeral D

Registrar

completely

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 [Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death utem 23a) (Type, Print)

Date filed (Month, Day,

29a. Certifier

one)

(Check only

Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. partment of Health and Mental Hygie State of Maryland 22415 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Horace Ferguson 00:35 AM 2010 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Multimedical Center 7700 York Road Towson, Maryland 21204 Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1927 North Carolina **Funeral** 1⊠M 2□F Director 293-26-1914 April 11, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Experimental any injury or other traumatic event, the Medical Experimental any injury or other traumatic event, the Medical Experimental any injury or other traumatic event, the Medical Experimental and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second and a second and a second a second and a second and a second a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6717 Yataruba Drive 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1944— If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2K No Specify: Specify: black þ 3 Widowed 4 Divorced Year or Dates: 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) dentist healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Benjamin Franklin Ferguson Julia Floyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Naiman - attorney 3835 Naylors Lane; Pikesville, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Simplify of Fire al Service Licensee Onald S. Wady, Director 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street 23a. Pan 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Oause (Final disease or condition resulting in death) **Physician** Cerebrovascular accident (probable) 7/7 Am (mins) /Medical Due to (or as a consequence of): **Examiner** Atheroscleratic Cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last months-years Due to (or as a consequence of): attending physician and for use as the burial-transit Atheroscleratic Cerebrovasaclar disease months Due to (or as a consequence of): Physician/Medical Atheroscierotic Peripheral Vascular disease years IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Large Left Acute Ischemic Infarction left parietal sagittal region 5/7/10 1 ☐ Yes 2 ☐ No 3 ☑ Frobably 4 ☐ Unknown Completed Old lacunar infarct Left in Ferior cerebellar humisphere 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed3 old lacunar infarct bilat the Umus; Hyperlipidemia; Hypertension 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Proursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760 after death.

To the Hospital or Attending Physician: e Funeral within 2

6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

Nurs Practitioner.

1 Certifying Physician. To the best of my knowledge, Jeath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Michaelle E Kalendek, CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R097104

July 7, 2010

Michelle E. Kalendek CANP Genesis multimedical Center 1700 York Road Towson, Maryland 21204 31. Date filed (Month, Day Year) UL 2 0 2010 32. Registrar's Signature

29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ZA Be ncon M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 W Months Days Hours Min. 02/20/1914 NY 96 052-07-1195 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 2 XNo BALTIMORE MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 21208 USA 1450 BEDFORD AVENUE, #215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) DRESSMAKER GARMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 BENJAMIN **EISENSTADT** REGINA HIMOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SYLVIA EGETH/DAUGHTER 11405 BELFIELD ROAD, OWINGS MILLS, MD Baltimore, 20a. Method of Disposition 20b. PARIOTHOTON/NCHIZUK 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 1 X Burial 2 Cremation 3 Removal from State AMUNO CEMETERY 07/18/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) INC. 21208 22. Name and Address of Facility 21. Signat 2. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ons t and Death † flysician Atherosale disease or condition Medical resulting in death) Examiner Securifically list non-cliffons if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Leat Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of nas autopsy death? perforn certificate Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009

1

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16 Gardner Month July Physician/ August 2010 2:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Rosedale Franklin Woods Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days June 6, 1932 Hours 1 🖾 M 2 🗆 F Maryland 78 Director 218-28-7512 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of out than "natural", or items 23a or 28a-f sho amy injury or rother traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5525 Lanham Way 21206 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 1949If Yes, Give 1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White 3 Widowed 4 Divorced 1952 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Bridal Shop Owner/Photographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Richardson Harry William Gardner, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5525 Lanham Way Baltimore, Maryland 21206 Mrs. Betty Gardner (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State Other (Specify) Entombmen 7/20/2010 4 Donation Moreland Mem. Park Baltimore, Maryland 21. Signature eral Service Lice Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 Wise Avenue Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pnysician/ Spiration day disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner month phas Sequentially list conditions, Examine as a consequence of if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Directors After the control of the state o use as the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Dav Pregnant at time of death detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 100 prior to completion of cause of rabets 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 (No Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 5 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5.17 per fh g905 7-27-10 vt. State of Maryland / Department of Health and Mental Hygiene 22418 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}201<u>0</u> Physician/ JULY 18 10:15 AM JOHN RAYMOND GAENG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford 417 Linwood Ave. 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb. 12 9. Birthplace (State or Foreign 5 Social Security Numbe 220-22-6871 **Funeral** Months Days Hours Min. Country)
Maryland 1 🔀 M 2 🗆 F Director 81 Usual Residence of Decedent 28a-f shov 10b. County event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò Funeral 23a 417 Linwood Ave. 21014 USA items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White, etc. ò 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: "natural", Completed 3 Divorced 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u> Account Executive</u> Advertisina Be 18. Mother's Name (First, Middle, Maiden Surname) . Father's Name (First, Middle, Last) **Francis G.** ည permit. Page 1 and 2 should be 1 Department of Health and Ments Important: If item 27 is marked (unk) Eleanor Rose Trageser Gaenq injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances deSales Gaeng/ Spouse 417 Linwood Ave., Bel Air, MD 21014 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 7-22-10 Forest Hill, Maryland <u>Ignatius Catholid</u> Funda 22 Name and Address of Facility McComas Funeral Home, P.A. any 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 545 IMETS disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury nding physician and use as the burial-transit sociation death certificate be executed that initiated events resulting in death) Last Due to (or as a nsequence of) Physician/Medical Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Po Month Day Year Pregnant at time of death the 9 Unknown P.0. Hospital or Attending Physician: The law requires that the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> No 3 Probably 4 Unknown Records, 1 Yes 2 Completed plnous been . Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 s autopsy performed his certificate h Il director, page 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer iniury Natural 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 61.

Registrar

31. Date filed (Month, Day, Year)

20

2010

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18 Day 2010 Pear Helen Irene Green July 1:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Country) 215-32-2582 1 □ M 2 🔀 F Months Hours Min. Director 95 Usual Residence of Decedent show 10a. State within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2909 Bird View Rd. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZNo Specify: If Yes, Give Year or Dates Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Seamstress Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည be William N. Barber Caroline Bitzel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron E. Green, Sr.-son 2907 Birdview Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Trinity Lutheran 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 7-22-2010Westminster,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician/ Non Course disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Preumemo that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death g Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 \square Yes 2 \nearrow No 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 performe Yes 2 No 2 🗌 No 1 🔲 Yes : After this certifical funeral director, p 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 📈 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Director: A Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my by wiedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exam ation and/or investigate n, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowled death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed of 21103 se of death (Item 23a) (Type), Print) heus Alexander Burles

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A NW Season's Hospice 21225 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday, Funeral Social Security Number 1 🛛 M 2 🗆 F Days Hours 05/18/1944 N.Carolina Director 240-68-5189 66 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3038 Southland Ave. 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ş 1 Never Married 2 K Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Self Club Owner 6th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harris Eleanor Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3038 Southland Ave., Baltimore, MD 21225 <u>Tanya Harris(wife)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 07/21/10 Baltimore, MD Woodlawn Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Joseph Hore Pagrown Jr. Funeral Home PA. 21217 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on expline. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ on disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been sig r, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🔀 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 200 Other: ည 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending 2 🗆 No 2 Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature And title of certifier

State Registrar ame and address of person who completed

31. Date filed (Month, Day, Year)

BOBMO

cause of death (Item 23a) (Type

State of Maryland / Department of Health and Mental Hygiene 2010 22421 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Kaczmarek 8.00 B Hoyas 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death al Baltimore Washington Medical Center AnneArund Glen Burnie 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months (Month, Day, Year) 02/17/1929 Country) Director 214-24-7445 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD Anne Arundel Co. Glen Burnie 1 ☐ Yes 2🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 1315 Howard Road 21060 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. 2 21215-0036 and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank Kaczmarek Julia Mechlinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carol Boudman / Daughter 518 Red Oak Drive Severna Park, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 07/23/2010 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01479 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deathy Immediate Cause (Final Physician/ disease or condition 4 week Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Autoimmuve resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicial completed filled in by the funeral director mans of second and accompleted filled in the signed and accompleted filled in the funeral director mans of second accompleted filled in the funeral director mans of second accompleted filled in the funeral director mans of second accompleted filled in the funeral director mans of second accompleted filled in the funeral director mans of second accompleted filled in the funeral director. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> MO Completed I 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Tes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Attandin flys cian 29c, License numbe 2010 44 10 325 Hojo potal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive 21061 140 GUNMEET S. SAWHNEY alen Brunie State AUG 1 7 2016 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Douglas Arthur 10-04721 Hamm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK	State of Maryland / Department of 1- For State Registrar Certificate of		ne 2010 22422
Physician	Decedent's Name (First, Middle,Last)	Mo	te of Death nth Day Year 1520 hrs
Medical Examine	Dodgias Michael Hamm	tb. City, Town, or Location of Death Baltimore	10 23, 2010 1530 115 4c. County of Death
Funeral Director	5. Social Security Number unit 6. Sex 7. Age (In yrs. last birthday)	Months Days Flours I will.	ate of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Unik
any.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	on	10d. Inside City Limits
≜ .∗!	MD Baltimore	2	1 🛣 Yes 2 🗌 No
ith the Maryland 23a or 28a-f show notified at once.		10f. Zip Code 21223	109. Citizen of What Country? USA
r death with or items 23	11. Marital Status Unik 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? unik 1 Yes 2 No	s Decedent of Hispanic Origin? (Specify Ses, specify Cuban, Mexican, Puerto Rican	
5-0036 led within 72 hours afte led within 72 hours afte lygiene. other than "natural", the Medical Examiner Commilered by	or Dates:	Yes 2 No specify: I's Usual Occupation (Give kind of work do ost of working life. DO NOT use retired)	on Unik 16b. Kind of Business/Industry Unik
21215-0036 ould be filed within 72 hour ould be filed within 72 hour ould be filed within 72 hour s marked other than "natt ic event, the Medical Exat		18.Mother's Name (First	Middle, Maiden Surname) UNK
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Taot: If item 27 is marked other than "natural", or items 23s or 28s-f short or other traumatic event, the Medical Examiner must he notified at once or other traumatic Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	·	Route Number, City or Town, State, Zip Code) more, Maryland 21201
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and In Important: If item 27 is n injury or other traumatic		ition (Name of cemetery, Date ner place)	20c. Location - City or Town, State
Baltir permit. F. Departme Importa- injury on			; 655 W. Baltimore Street
Physician /Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardi		ratory arrest, shock, or heart Approximate Interval Between Onset and Death
1	or condition resulting in death) Due to (or as a consequence of): b. b. Due to (or as a consequence of): b. Due to (or as a consequence of):		
ed nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):		
0, be executed sician and burial - transit			88 4 - SS-247 C-14
lox 6876 eath certificate a attending phy for use as the l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	tal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
res that the designed by the a be detached if		inderlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown
Division of Vital Records, talor Attending Physician: The law requirement and Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed			24a. Was an autopsy performed? ✓ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Check only o	
ion of Virtending Physiceath or: After this the funeral direction: To	27 Manner of Death 28a Date of Injury 28h Time of In		Describe how injury occurred
Division o vithe Hospital or Attending within 24 hours after death To the Fuoeral Director: After completely filled in by the fune edical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street (Specify)		ocation (Street and Number or Rural Route Number, City or Town, State)
DIVI To the Hospital or within 24 hours after To the Fuocral Dir completely filled in ledical Certifi	CertifyIng Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	ion, in my opinion, death occurred at the t	
	29b. Signature and title of certifier Covered Hallon	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) June 24, 2010
	In a second	Street, Baltimore, MD 21201	
State Registra		Kel	
DHMH 17 Rev 1/2001	ORIGINA		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year mary 3:40AM E Hemicke 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville <u>Baltimore</u> 5. Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 28, J 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 □**X**F Hours Country)
Maryland 212-20-5698 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore MD Catonsville 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a Funeral 719 Maiden Choice Lane BR 232 21228 USA items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give þ 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 → Widowed 4 □ Divorced Completed Year or Dates the Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Technician Bendix Radio other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter D. Mumford Alma E. Knauff 19a. Informant's Name/Relationship (Type, Print) Mary E. Taneyhill Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10225 Burnside Drive; Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date 1
Burial 2
Cremation 3
Removal from State c Crematory 17/16/2010 Glen Burnie, MD

22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc.

1630 Edmondson Avenue; Catonsville, MD 21228 injury 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licens any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Renal disease or condition resulting in death) Fa Medical Due to (or as a consequence of transplant **Examiner** Sequentially list conditions. Examine il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? ☐ Yes 2 🖼 No ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by kidner transplant 1 Yes 2 No 3 Probably 4 Unknown Records, chould been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/13/10 カイヤステチ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day Year)

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maiden

. Registrar's Signature

choice Lane, Catonsville,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 2010 11:30 AMM Douglas Gene Howlett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center <u>Towson</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Months Hours 02/15/1957 Maryland Director 53 212-70-8471 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2X No Kingsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21087 U.S.A. 11320 Cedar Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. à 1 X Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates White Specify: Completed 3 🗆 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hyglene. Maryland State Bay Pilot Maritime traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever မ Alberta Lorraine Allmond Eugene Franklin Howlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1332 Springvale Drive - Bel Air, Maryland 21015 <u>Diana L. Pajtis (sister)</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem U.M. Ch. Cemetery 07/23/10 Upper Falls, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. aa <u> 11750 Belair Road - Kingsville, Maryland</u> 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Glioblaston Ph sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) If any, leading to immediate attending physician and for use as the burial-transit Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has 1 Yes Yes 2 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No M Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29b. Signature and title of certifier

Gerst towner, m

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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TOWFON, MOZIZOM

		-	State of Ma		artment of Health and tificate of Death		giene Reg. No. 2010	22425
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			Date of Dea Month	th Day Year	3. Time of Death
	Medic	al	JEAN JOSEPH JACO	OB	d O' Town or book of Doo	JULY	14, 2010	
	Examin		4a. Facility Name (if not institution, give street and number) 8701 Fallen Oak Drive		4b. City, Town, or Location of Dea Bethesda		4c. County of Death Montgomer	У
	Funeral Director		578-42-8459 1 X M 2 G F	(In yrs. last birthday) 77 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Min		(Year) Cou	nplace (State or Foreign ntry) Algeria
	show at	5	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation			10d. Inside City Limits
	Maryla 28a-f	Director	MD Montgomery	Bethesda				1 ☐ Yes 2 🖾 No
	with the s 23a or s	Funeral D	10e. Street and Number 8701 Fallen Oak Drive		10f. Zip Code 20817		10g. Citizen of What Cou USA	intry?
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent E Armed Forces? 1 ▲ Yes 2 ☐ If Yes, Give Year or Dates. ■	No If	Vas Decedent of Hispanic Origin? (f f Yes, specify Cuban, Mexican, Puer Yes 2 No Specify:		14. Race - Ameri Black, White Specify: Whi	, etc.
15-0	"2 hou "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give F	lent's Usual Occupation kind of work done during most of wo	orking	16b. Kind of Business I	ndustry
7121	vithin 7 iene. ir than the M		Elementary/Seconday (0-12) College (1-4 or 5		ONOT use retired) Less Owner	ı	Gourmet Foo	d Services
land 2	be filed w ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Jean Henri Jacob			ame (First, Middle, i Tordjman		
Maryland	12 should alth and M 27 is mar r traumat		19a Informant's Name/Relationship (Type, Print) Elizabeth Jacob, wife	8701 8701	Address (Street and Number of Fallen Oak Drive	ural Route Number Betnesd	a, MD 20817	Code)
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place)	Date 3/2010	20c. Location - City or Falls Churc	
Baltir	permit. P Departm Importar any injur		21. Signature of Funeral Service Licensee	M01539 22	Name and Address of Facility Ra	pp Funer	al & Cremat	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente				Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition COMPLI	CATIONS OF	DEMENTIA			Onset and Death
	Medical Examiner		resulting in death) Due to (or as a	a consequence of):				
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-	ate be executed physician and the burial-transit	sal E	resulting in death) Last Due to (or as a	a consequence of):				
120	icate t g phys is the	ledical I	d					
Box 687	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 L	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
P.O.	that the des ned by the s detached	y Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the u	inderlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
	requires the been signer should be	ted b				1 🗆 `	Yes 2 No 3 Pr	obably 4 Unknown
ecor	The law rectate has be page 2 sho	Completed by		-		24a. Was a autop perfo	prior to c	opsy findings available ompletion of cause of
al B	sician: The certificate rector, pag	Be Co	25. Was case referred to medical		26. Place of Death (Ch		2 A No 1 ⊔ Yes	2 No
Zi.	Physici this cer al direc	To E		ent 2 ER/Outpatier			dence 6 Other (Speci	fy)
on of	ending P sath. or: After t he funera	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation (Month, Day	ry 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injuiding, etc	ıry - At home, farm, stro c. (Specify)	eet, factory, office	28f. Location (S City or Tow	Street and Number or Rur n, State)	al Route Number,
	Hospital 24 hours a Funeral C	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of e	xamination and/or invest	tigation, in my opinion, death occurre	d at the time, date a	nd place, and due to the o	ause(s) and manner stated.
	To the within 2 To the Comple	Σ	only one) 3 Certifying Nurse Practioner: To the		29c. License number		e cause(s) and manner as a 29d. Date signed (Month	
			29b. Signature and title of certifier landy		#D0058627		JULY 15, 20	10
	net		30. Name and address of person who completed cause of d					
	7	10		50 IRVING	STREET NW. WASH	INGTON, DO	20422/688	
	Sta Registr		1111 2.0 2010 A	hard				

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	_	For		State of I	Marylan					lental Hy	gien	e o o l o	2	01.00
	1	State Registrar	_ 			Cei	tificate c	of Death	7			ZUIU		2426
Physiciar	/	1. Decedent's Nam Dra		.ast)	Jova	novsk	i			2. Date of De Month July		2010 Year		Time of Death
Medica Examine	_			ive street and number		110 1 011	4b. City, Tow	n, or Locatio	n of Death	Jury	$\neg \neg$	c. County of De		• 13 A
				an Nursir				Ltimo						
Funeral Director		5. Social Security N 212-36-	6476	. Sex 1 🔀 M 2 🗆 F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 You Months Da	ear If Und ays Hours	ler 24 Hrs. Min.	8. Date of Bir (Month, Date 3 – 1 9	th ly, Year) 922	Yu	irthplace (country) gos1	(State or Foreign .avia
nd how	- 1	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation						10d. In	side City Limits
Aaryla 8a-f s tified	l ect	Md				Balt	imore						1	Yes 2 No
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fer of amin	2	11. Marital Status 1 ☆ Never Marr 3 □ Widowed		Armed Forces	s? 🗙 No		f Yes, specify C	Cuban, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)		14. Race - An Black, Wh Specify: Wh	ite, etc.	dian,
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ylal	2	Mihajl			Jovai	novic			ostar			idova		
, Maryland nd 2 should be filed alith and Mertal Hy n 27 is marked oth ler traumatic event		19a. Informant's Na Mario V		nta - God	dson							le, Md		1093
Baltimore, permit. Page 1 and pepartment of Hea mportant: If item my injury or other				Removal from Sta	ite c	emetery, crer	sition (Name of natory or other undel	place)	İ	Date		Location - City o		
Baltimore permit. Page 1 a Department of H Important: If ite any injury or ot	Ì	21. Signatur Fu			- Twee	22	. Name and Ad	ddress of Fac	ility до:	seph N	. 2	Zannin	o Jr	. F.H.
	+	23a. Part 1, Enter t	he disear, or co	implications that caus	sed the death	- 12	63 5.	Conk	<u> </u>	St. B	<u>sa i t</u>	imore	Ma	21224
hysician/		shock, or hear Immediate Cause (disease or condition	rt failur∕. List only Final											val Between et and Death
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Divisic all or Atte s after des I Director d in by th		3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	28e. Place of I	njury - At ho etc. (Specify,		eet, factory, off	ice		28f. Location (S City or Tov		nd Number or F e)	iural Route	e Number,
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To the within		29b. Signature and	title of certifier	o completed cause of	Lu	7/	29c. Lic	SF5	ט ל		29d. D	ate signed (Mor	nth, Day, Y	
2		30. Name and addre	ess of person wh	o completed cause of	f death (Item	23a) (Type, F	-6010	loch	Ka	ven b	8/0	d'B	11	imure
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			For State		State of M	larylan	id / Depi	artment of I <i>rtificat</i> e <i>of L</i>	Health and	Mental Hy	giene	2010	22427
			Registrar 1. Decedent's Name	(First, Middle,			061	tincate of L	Jeann	2, Date of De	Reg. No.		3. Time of Death
_	sicia /ledic				Leona Ro	osema	ry Jac	obs		Month July	13 ^{Day}	2010 Year	7:05 P ^M
	amin				give street and number)			4b. City, Town, or	Location of Deat	th	4c.	County of Deatl	h
F. C.	- nal		1111 Mon ^o 5. Social Security Nu			ne /In vine k	ast birthday)	Laurel If Under 1 Year	If Under 24 Hrs	8. Date of Bir		Prince (
Fun Dire			473-32-6	257	1 □ M 2 🔀 F	76	Yrs.	Months Days	Hours Min				hplace (State or Foreign untry) nesota
pu wo q:	at	or	Usual Residence of I 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Aaryla 8a-f s	tified	Director	MD	Princ	ce George	La	urel						1 🌠 Yes 2 □ No
a or 2	pe no	Ι	10e. Street and Num					10f. Zip Code		Ţ	10g. Citi	izen of What Co	untry?
h with	must	Funeral	1111 Mon	trose A				20707			U.8	S.A.	
nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It if item 27 is marked other than "natural", or items 23a or 28a-f show	aminer	þ	11. Marital Status1 Never Marrie	ed 2 🔀 Marri	ed 12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give			Vas Decedent of H f Yes, specify Cuba I □ Yes 2∑ No	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)		14. Race - Amer Black, White	
21215-0036 within 72 hours after giene. er than "natural", o	al Ex	Completed	3 Widowed 4		Year or Dates.								ite
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uld be	natic		Roy Gagno							da Boule			
Mal 2 sho 1th and 27 is r	traur		19a. Informant's Nar Ronald Ja		p (Type, Print) / spouse			Montage					*
Te, and I Heal	other		20a. Method of Dispo		/ spouse		lace of Dispo	Montrose sition (Name of		Date	r i	ry Land 2 cation - City or	· · · · · · · · · · · · · · · · · · ·
imor Page 1 Tent of ant: If it	ury or		1 X Burial 2 ☐ 4 ☐ Donation		3 ☐ Removal from State	, I	-	natory or other places s Cemete:		20, 10		rel, Ma	
Baltimore, Maryland permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth	any inj		21. Signature of Fun	eral Service Li	cense	м007	773	Name and Address Donaldson 313 Talbo	s of Facility Funeral	Home,	P.A.		_
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use of the burds of the physician and	sn loi nau	Physician/M	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 🛣 9 ☐ Unknown	onths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 - Feta	Ideath 3	Ectopic pregnanc Other (specify)	у		2	23d. Date of deli Month	very Day Year
P.O. that the ned by	dela	by Pi	Part II. Other signific	ant condition	s contributing to death b	out not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?
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fital Rec sician: The lar certificate ha	I, pag		25. Was case referred	t to medical	1			00 51	. D	1 Yes			2 🗆 No
Vita /sicial s certi	necre	To Be	examiner? 1 \(\sum \) Yes 2 \(\overline{K}\)		Hospital:	ent 2 🗀 I	ER/Outpatien	Otho	r:	<i>ck only one)</i> Iome 5 ☒ Resid	donas C	Other (Creek	6.0
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ION tendir leath. or: Af		ilica I	2 Accident	Investiga	ation			M 1 □	Yes 2 No				
DIVIS all or At s after c al Direct	λα III	Certificate:	4 Homicide	determin				et, factory, office		28f. Location (S City or Tow		Number or Rura	al Route Number,
ne Hospit n 24 hour ne Funera		Medical	29a. Certifier 1 (Check 2 only one)	_ Medical Ex	Physician: To the best of aminer: On the basis of e lurse Practioner: To the	xamination	and/or invest	igation, in my opinio	n, death occurred	at the time, date a	ind place.	and due to the ca	ause(s) and manner stated.
Vithi To th			29b. Signature and til					29c. License				e signed (Month,	
			19	121				D006	0812		Jul	y 14, 2	010
D)		30. Name and addres Robert L		no completed cause of d		, , , , ,	rint) Wolfe S	treet, B	altimore	e, Ma	ryland	21287
	State istra		31. Date filed (Monte,	0 2010			park						

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AMEND ITEM#20b, perFH, G905, 7/2072010, WS

State of Maryland / Department of Health and Mental Hygiene 2 0 | 0 22428 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2010 Year Wilson James Julius, Sr. July 16, 30p м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1800 Hollins St Apt#220W Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. oct. 22 1 XM 2 - F 248-54-9399 **Director** Usual Residence of Decedent 10a, State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1800 Hollins St. Apt. 220W 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: 3 Divorced Specify: Black Year or Dates other traumatic event, the Medical 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security 8th N/A Masonry <u>Construction</u> Be 17. Father's Name (First, Middle, Last) Eugene Julius 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H .. Page 1 and 2 should be filk tment of Health and Mental tant: If item 27 is marked o Lucille Jennings 19a. Informant's Name/Relationship (Type, Print)
Hannah Julius/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4405 Norfolk Ave. Baltimore, MD 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/26/2010 1 Burial 2 Cremation 3 Removal from State Druid Ridge Cem injury or Department of Important: If any injury or Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitBeverly D. Cromartie F/S Duck 2700 Edmondson Ave. Balto., MD 21223 25. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Amhyalmin Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Car Sequentially list conditions cause. Enter Underlying Exami attending physician and for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown ate has been signed by the a page 2 should be detached f 1 ☐ Yes 2 ☐ No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Caronary Antery Disease Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗶 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, [25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation M 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 022342 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victorel N. Robinster 3333 N. Calvert St. MO. 32. Registr State Registrar

Box 68760

P.O.

10-04911 Howard Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2010 22429

		1- For State Registrar		Ce	ertificate (of Death				Pon No	• • •	
Physicia Medical Examin	ın/ ner	Decedent's Name (First, Midd Howard Johnso	on						2. Date of Month June 3		Year	3. Time of Death
		4a. Facility Name (if not instituti 5709 Veron Way	on, give street and nu	ımber)		4b. City, Too Suitlan		cation of De		4c. Cou	nty of Death e George's	s
Funeral Director		5. Social Security NumberUnk	6. Sex	7. Age (In yrs.	E.6	If Under Months	1 Year Days	If Under 24	. 1	f Birth(MM/DD/Y) 3, 1954	YYY) 9. Birth Foreign Cour	
D 21215-0036 hould be filed within 72 hours after death with and Mental Hygiene. is marked other than "natural", or items 23 tis revent, the Medical Examiner must be an expectation of the manual and the mast be an expectation.	Be Completed by Fune	10e. Street and Number 5709 Veron W. 11. Marital Status UTK 1 Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12) UNK 17. Father's Name (First, Middle,	ay 12. Was Dec Armed For 1 Yes, Give Year or Dates: College (1: unk Last) Unk	edent Ever in Unrose? unk	16a. Decede during r	as Decedent Yes, specify C Yes 2 Int's Usual Ocnost of working	46 of Hispan Cuban, M No s Cupation g life. DC	lexican, Puer specify: (Give kind of NOT use re Mother's Nan	Specify Yes or to Rican, etc.) ¹ If work done United) the (First, Middle Rural Route N	10g. Citizen of USA No- unk Specif 16b. Kind of e, Maiden Surnar	What Countriace - America hite, etc. UTi	in Indian, Black, ustry Unk
Baltimore, MD Spermit. Pages I and 2 shou Department of Health and Important: If item 271s injury or other tramptic		O. C. M. E. Oa. Method of Disposition Durial 2 Cremation Donation 5 A Othe Sp Signature of Euneral Service	ecify: in stat	m State	Place of Dispo crematory or of	sition (Name of ther place)	ress of F	ery, acility My Boa	Date 1rd; 65	5 W. Bal	n - City or To	wn, State
Physician /Medical Examiner	li o	3a. Part Enter the disease, or failure List only one cause of mediate C use (Final disease or condition resulting in death) equentially list conditions, any, leading to immediate or injury that initiated vents resulting in death). Last	omplications that car on each line. a. Atherosclero Due to (or as a c b. Due to (or as a c c. Due to (or as a c	otic Cardiov consequence of consequence of	ascular Dis	he mode of dy	ring, suci	h as cardiac	and 2120 or respiratory a	JI arrest, shock, or h		Approximate Interval Between Onset and Death
Box 68760, e death certificate be execu the attending physician and ed for use as the burial - tra hvsician/Medical	IF 23	FEMALE: D. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown II. Other significant condition	1 Live birt 4 Pregnar 9 Unknow ons contributing to d	nt at time of dea n eath but not re	2 Fell	al death ner (<i>Specify</i>) nderlying caus		ctopic pregna	23e. Did		Day ribute to the c Probably Were autopsy	
Division of Vital Records, P.O. tal or attending Physician: The law requires that the star death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach stiffication: To Be Completed by P.	25	Was case referred to medical examiner? 1 Yes 2 No Manner of Death W Natural 5 Pendin	28a. Date of (Month, Da	Injury I	ER/Outpatient 28b. Time of In	3 DOA	Other	Vork?	1 Yes only one) g Home 5	ormed?	death? Yes Other: Sce	2 No
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune edical Certification:		Accident Investig Suicide 6 Could r Homicide determinence only Certifier 1 Certifying Physics	gation anot be ined (Specify) sician: To the best of	f Injury - At hon	, death occurre	, factory, office	date and	g, etc.	or Town, S	State)		oute Number, City
To the Hi within 24 To the Fr completel	30.	Gignature and title of certifier	and manner state	f death (Item 2	3a)	n, in my opini	on, death	n occurred at	the time, date	and place, and d 29d. Date sign July 1, 201	ue to the caused (Month, D	
State Registrar HMH 17 Rev 1/2001 CME 2006	31.	Date filed (Month, Day, Year) JUL 202	32. Regist	trar's Signature		e d	Jailiii	OTE, IVID 2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 1 0 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAMES WILLIAM JOHNSON, JR. 16:12 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore City GOOD SAMARITAN HUSPITAL 1 Year If Under 24 Hrs If Unde 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) Funeral Months Davs Hours Min Mar. 25, Y1922 Marvland 88 215-14-6898 Director Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2**X** No Frederick Marvland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 Funeral 900 Shawanee Drive USA 07/14/10 12. Was Decedent Ever in U.S.
Armed Forces?

★★★ Yes 2 □ N★₩ 11
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ XXNever Married 2 Married 1 ☐ Yes XX No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates , JAMES W. MR#901052061 U. S. Government 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 눔 8 yrs. Fort Detrick Microbiologist ¥. yrs. Be 18. Mother's Name (First, Middle, Maiden Surname)
Emma Douglas 17. Father's Name (First, Middle, Last) James William Johnson, Sr. JOHNSON , JI PT#102465660 03|25|1922 88 M SCOTT, PENELOPE P P TEAM Σ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vita Kencel (Niece) 606 Deerrock Rd. Bel Air, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley M. G.: 7-18-2010 Baltimore, Md. 22. Name and Address of Facility
Lassahn Funeral Home Signature of Funeral Service Licenses 7401 Belair Rd. assa Baltimore. Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ Intracranial disease or condition resulting in death) hemorrhage Medical Due to (or as a consequence of): Examiner Hybertensian
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown Ectopic pregnancy for in the past 12 months? Month Dav Year 5 Other (specify) 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed' 1 Yes 2 🔊 funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital ၉ 1 Tes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural injury 5 Pending s after death.

I Director: Aft
d in by the fur 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number RES 000 July, 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

20 2010

och Raven

5601

32. Registras Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#9perFH, G905, 7/20/2010, WS#1perPHYS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Bertha 2. Date of Death Knox Lee Day Physician/ 2017 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMORE m m 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 413-56-4163 1 □ M 2 🗙 F Months Davs Hours Min. 08/24/1934 Tennessee 75 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No TN. MEMPHIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral 38108 items 23a 1492 ORIOLE U.S.A. STREE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Black White, etc. "natural", or ò 1 Never Married 2 Married ☐ Yes 2 No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: BLACK 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) HOME MAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ "leophus WISEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PIRATES COUE Columbia, MARYlAND 21046 DARREIL KNOX 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State memphis, Tennessee 22. Name and Address of Facility The DERRICK & JONES FIH, P.A. 2010 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Se Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequance of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autonsy 1 Yes 2 No Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 2 🗆 No Accident Investigation Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Medical 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and t 29d. Date signed (Month, Dav. Year) 29c, License number 92220792 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

BOWLS I TARE

Date filed (Month, Day, Year,

ark

32. Registrar's Signature

GREENE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Year July 16, **Physician** 645a John Kajdas /Medical 4c. County of Death Calvert 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Federick Frince Fear If Under 24 Hrs. 8. Date of Birth (Month, Day, Tuly 2, Calvert Hospice Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1967 Country, NY 1 □ M 2 □ F 43 072-68-3344 July Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Calvert MD Lusby Director 1 ☐ Yes 24 ☐ No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 640 Santa Fe Trail 20657 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specif White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer Engineering 12th 17. Father's Name (First, Middle, Last) Edmond J. Kajdas 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy A. Szuba ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kimberly Kajdas/Spouse 640 Santa Fe Trail-Lusby, Md. 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) Final Journey 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 7/19/10 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facilit Charisse 21. Signature of Funeral Service License Woods 2700 Edmondson Ave. 23a. Part. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a c in equence of): Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: fyes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Hlnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother Specify 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

Examiner The law requires that the death certificate be executed P.O. Box 68760,€ Division of Vital Records, certificate

physician the as attending properties of ed by the been signed be should be deta cate has t To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p

2

Completed

Be

Certification: To

Medical

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or nitems 28a or 28a-f show any or other traumatic event, Ita Marical Exp. niture mast be notified at

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

Physician

/Medical

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show It e Medical Exp. citter must be notified at

5 Registrar

State

Jacus CRUP

29c. License number

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4559 Sixes Road PrinceFrederick MD 206 Fo Tiffany Octives

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

(Check only one)

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10 ay July 2010 Edward William Knauer 12:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Year 927 1 🗆 M 2 🗆 F Feb 13, Maryland **Director** 217-22-1604 83 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at Completed by Funeral Director 10d. Inside City Limits Baltimore Kingsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 7017 Mount Vista Road 21087 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Heatth and Mental Hygiene. Important; If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces?
1 ☑ Yes 2 ☐ No 1946-Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: white If Yes Give 3 Widowed 4 Divorced 1949 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry unit 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) meat cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be Joseph John Knauer Margaret Cathrine Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7017 Mount Vista Road; Kingsville, MD 21087 Tammy McGuire - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4[™] Donation 5 ☐ Oher (Specify) Sign ture of Funeral Pervice Licensee nald S. Was 2812120 Affatoffy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or c dition resulting in de th) Ph_{sician/} ALZHEIMER'S DISEASE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death **To the Funeral Director:** After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached to g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPTCE** 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural iniury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

P.O. Box 68760 EDWARD Division of Vital e Hospital or Attending P 124 hours after death. e Funeral Director: After t

> Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

(Check

only one) Signature and title

JACKÍE JONES,

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

istrar's gnature

address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

City or Town, State)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			For State Registrar	State of Ma	aryland	Cer	irtment of t tificate of t	Death		Reg. No.	010	22434
П	Physicia	n/	1. Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Medic	al	William Freder		in				07	19	2010	4:30 AM M
	Examin	er	4a. Facility Name (if not institution	,				r Location of Deat	h		ounty of Death	
	Funeral		Stella Maris I 5. Social Security Number	6. Sex 7. Age	e (In yrs. last	birthday)	Timoni If Under 1 Year	If Under 24 Hrs		th	altimo	place (State or Foreign
	Director		219-01-6235	1 X M 2 □ F	88	Yrs.	Months Days	Hours Min.	06/15/	y, Year) 1922	Cou. Ma	ryland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loc	ation					10d. Inside City Limits
	faryla 8a-f s tified	Director	MD Balt	imore	Bal	.dwin						1 🗆 Yes 2 🐰 No
	the Na or 2		10e. Street and Number				10f. Zip Code			10g. Citizer	of What Cou	intry?
	h with	Funeral	5331 Sweet Air				21013			U.S	.A	
	r deat or iten iiner r	by Fu	11. Marital Status 1 ☐ Never Married 2X Mar	12. Was Decedent E Armed Forces? 1 X Yes 2	ver in U.S.	13. V	as Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	Race - Ameri Black, White,	
036	safte ral", c Exer		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1944 ∾ 1973		☐ Yes 2 🔀 No	Specify:		Spe	ecify: Whi	te
5-0	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Exeminer must be notified at	Completed	15. Decede (Specify only highe	nt's Education est grade completed)		16a. Deced	ent's Usual Occup	ation during most of wo	rkina	16b. Kind	of Business Ir	ndustry
121	thin 7.	Som	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. DC	NOT use retired)	-	9	TI C	Moudoo	Const
9	불충수명	Be	17. Father's Name (First, Middle, I	<u> </u>		T11T-	antry Of		me (First, Middle,		Marine	corp
/lar	d be fill Mental arked o	으	John Henry Koe	ehnLein				Helen	Augusta	Kraft	-	
Maryland 21215-0036	should be fil h and Mental 7 is marked or raumatic eve		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numbei	r, City or Tov	vn, State, Zip	Code)
	and 2 s Health tem 27		Marie A. Koeł 20a. Method of Disposition	<u>nlein (wife</u>	4		Sweet A	ir Road	<u>Baldwi</u>		ryland	
mor	age 1 ent of nt: If ii y or c		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cem	etery, crem	atory or other place		2/2010		-	
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er once.		21. Signature of Funeral Service I		Touta							Home, P.A.
<u>m</u>	28 2 8 8		► E. G. C	Lassahn				ir Road				
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each line	the death. [Do not ente	the mode of dyin	g, such as cardiad	or respiratory arr	est,	77	Approximate Interval Between
100,0	Priysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. MELANOM								Onset and Death
	Examiner			Due to (or as a	consequen	ce of):						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequen	ce of):						
f.	ecuted and transi	xam	Cause (Disease or imjury that initiated events	c. ————————————————————————————————————	000000000	00.00						
7/	be exe	edical Examiner	resulting in death) Last	Due to (or as a	consequen	ce oi).						
3760	ficate g phys	/edi		d								
89 x	h certi	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	of pregnancy 2 Fetal de	eath 3 🗆	Ectopic pregnand	ev.		230	I. Date of deliv	very
Box	e deatl the att hed fo	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Month	Day Year
P.O.	at the		Part II. Other significant condition	ns contributing to death be	ut not resulti	ng in the ur	derlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
<u>S, I</u>	uires t n sign uld be	ed by							1 🗆 1	res 2	No 3 🗆 Pro	bably 4 🗆 Unknown
Sorc	w require been so shou	Completed							24a. Was a		4b. Were auto	psy findings available ompletion of cause of
Rec	The la ate ha page	Som		_					autop perfor 1 🗆 Yes	med?	death?	
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital;			26. Pl	ace of Death (Che	ck only one)			
<u>~</u>	Phys r this o	은 일	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER	Outpatient	3 DOA 28c. Injury	4 U Nursing F	forme 5 Resid			HOSPICE
ou c	nding ath. r: Afte ie fune	icat	1 X Natural 5 Pendir 2 Accident Investig		Year)	injury	work		200. Describe in	ow injury oc	Curred	
Division of Vital Records,	al or Attends after death	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ			, farm, stre	et, factory, office		28f. Location (S City or Tow		ımber or Rura	I Route Number,
۵	pital o		One Contiller 1 1 Contitue	Dhuniafan Ta tha bast of								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 L Medical E	Physician: To the best of a xaminer: On the basis of ex Nurse Practioner: To the b	amination an	nd/or investi	ation, in my opinio	on, death occurred	at the time, date as	nd place, and	d due to the ca	use(s) and manner stated.
	To the withing to the complete	-	29b. Signature and title of certifier	- 24 10		30,	29c. License				gned (Manth,	
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	Stat	e e	JACKIE JONES, 31. Date filed (Month Day Year)	32. Registra	s Signature	Y VAL	LEY RD.	TIMONIU	M, MD 21	.093	-	
				The second of the	9 751/1	The State of the S						

DHMH 17 Rev 7/2009

4:30 a.m.

JULY 19, 2010

WILLIAM KOEHNLEIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17^{ay} 2010^{ear} Physician/ 1:25 P M Charles W.Klipper, Jr. Junto Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Min. Mary Tand 214-14-4250 Director 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Mary land Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #1507 21286 205 E. JoppaRoad U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Aero Space Writer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret E. Radford Charles W. Klipper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Klipper/Brother 204 E. Joppa Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 7/20/2010 Timonium, Maryland Dulaney Valley Mem. Gdns. 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or co shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PMP 700 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မှ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40212 CM, 405M State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 22436 State of Maryland / Department of Health and Mental Hygiene 20 10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010 Physician/ Hwan Kim 9:30 A M Julv Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Manor Care Dulaney Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. 0000 Petro Year 932 Korea **Director** 327-72-5855 77 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Det artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mary land Baltimore Hunt Valley 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32 White Pine Court 21030 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Convinence Store Store Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kim Heung Chun Ghong Koma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HeeSun Kim/ Daughter 32 White Pine Court HuntValley, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Hilltop Service Corp. 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State 7/19/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final with Asut Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed?
Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No ✓ Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

29b. Signature and title of certifier

Ron 31. Date filed (Month, Day, Year

non-Par Kion

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

rar's Signature

29d. Date signed (Month, Day, Year)

031861

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0 Medical acility Name (if not institution, give street Examiner City, Town, or If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Hours Min. Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** 1 🔀 Yes 2 🗌 No 10e. Street and Number 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 X Yes 2 ☐ No Specify: HONDUNAIN 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) aboi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First ပ Important if item 27 is mark any injury or other trees. (ROUSIN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗐 Removal from State 22 Monjaras, Buelow vena 4 ☐ Donation 5 ☐ Other (Specify) Signature of uneral Service Licenses DC 2001 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) 4 Pregnant a completed filled in by the funeral director, page 2 should be detached After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably Multinown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🗆 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? ✓ Natural 5 \square Pending death. Accident Investigation within 24 hours after deat To the Funeral Director. Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the d 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific License number

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

pleted cause of death (Item 23a) (Rype, Print)

32. Registrar's Signature

10-05233 Mark C. Linton, JR. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 22438 State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	Certificate (of Death		Reg. i	No.	
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Mark Charles Linton,	Jr.			2. Date of Death Month Da July 12, 2010	ay Year)	3. Time of Death 2102 hrs
4		 Facility Name (if not institution, give street and not St. Agnes Hospital 	umber)	4b. City, Town, of Baltimore	r Location of Deat	n	4c. County of Deat	
Funeral Director		5. Social Security Number 1841 6. Sex 1 X M 2 F	7. Age (In yrs. last birthday)	If Under 1 Year Months Day			MM/DD/YYYY) 9. Bi Forei , 1983 C	
nd how any <u>ce.</u>		Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town or Loc	cation Lansdown	e			10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f show diffed at once.	Director	10e. Street and Number 3119 Ryerson Circle		10f. Zip Code	21227	10g.	Citizen of What Cou United	
Baltimore, MD 21215-0036 pemir. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed F 1 Yes 3 Widowed 4 Divorced If Yes, Give Ye	forces? If	Was Decedent of Hi f Yes, specify Cuba			White, etc.	rican Indian, Black, White
72 hours after "natural" al Examine	eted by	15. Decedent's Education (Specify only highest gra	de completed) 16a. Deced	dent's Usual Occupa most of working life	ation (Give kind of		b. Kind of Business.	/Industry
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medics	Completed	12 2 17. Father's Name (First, Middle, Last)	Ge	eneral Co		e (First, Middle, Maid		oration
21215 uld be file Mental H marked c	Be	Mark Charles Linton, 19a. Informant's Name/Relationship (Type, Print)		ling Address (Stre		e Ann Fei Rural Route Numbe		e, Zip Code)
and 2 short ealth and tem 27 is traumatic		Arlene Ann Linton-mother 20a Method of Disposition	3119		Circle I	Lansdowne		
Baltimore, permit. Pages I an Department of Hee Important: If ite		1 Burial 2 XCremation 3 Removal for 4 Donation 5 Other Specify:	rom State crematory or Altantic	otherplace) c Cremato	ry 7-	18-2010		rnie, MD
	1	Patture an Black	1	2719 Hamm	onds Fry	Rd., Lan	sdowne, M	d 21227
Physician /Medical Examiner	i		Drug (Methada consequence of):					Approximate Interval Between Onset and Death
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated	a consequence of):					
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tox 68760, eath certificate be a sattending physicia for use as the burit	sician/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	birth 2 nant at time of death 5				23d. Date of deliver Month	ry Day Year
ords, P.O. B w requires that the d s been signed by the	by Phy	Part II. Other significant conditions contributing t		e underlying cause	given in Part I.			the cause of death?
2 a a 2	Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Vital Rec ysician: The l his certificate l director, page	æ	25. Was case referred to medical examiner?	Inpatient 2 PER/Outpatie		e of Death (Check	only one) ng Home 5 Re	sidence 6 Othe	er:
on of V ending Phys ath. nr: After thi	tion: To	27. Manner of Death Natural 5 Pending 7–12	e of Injury 28b. Time o	of Injury 28c. Inju	ury at Work? Yes 2 X No	28d. Describe how		
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	4 Homicide Could not be determined (Specify,	ce of Injury - At home, farm, st	treet, factory, office	building, etc.	or Town, State	e)	ural Route Number, City Halethorpe ,
Dj. To the Bospital owithin 24 hours a To the Funeral I completely filled	ledical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis and manner:	of examination and/or investig	curred at the time, c gation, in my opinio	late and place, and n, death occurred	d due to the cause(s at the time, date and) and manner as sta I place, and due to t	ted. he cause(s)
	Me	29b-Signature and title of certifier		29c. Licen O.C	se number .M.E.		9d. Date signed <i>(Me</i> uly 13, 2010	onth, Day, Year)
		30. Name and address of person who completed cau Zabiullah Ali, M.D. Assistant Medic	cal Examiner 111 Pe	enn Street, Bal	timore, MD 21	1201		
Sta Registr	ate rar	31. Date filed (Month, Pay, Yeg) 0 2010 32. R	e istrar's Signature	barke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Cynthia Denise Lattimore July 2300 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death 5107 Goodnow Road # Baltimore N/A Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 216-62-1776 1 □ M 2X□ F oct. 11, 1953 COUPTY) 56 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County N/A permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State MD 10c. City, Town or Location 10d, Inside City Limits Director Baltimore 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5107 Goodnow Road Apt. 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 SpB.Lack 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Heileman Elementary/Seconday (0-12) 12th College (1-4 or 5+)
N/A Machinist Brewery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Lattimore Gladys Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2803 Gresham Way # 202 Woodlawn Md 21244 Nakia Lewis/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 7/24/10 Final Journey 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., 21223 MD23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ pertension disease or condition resulting in death) Medical or as a consequence of) Examiner cerebral vascular accidents Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death signed by the a Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated itle of certifier 29b. Signature ar 29d. Date signed (Month, Day, Year) 30. Name and/ad ess of person who completed cause of death (Item 23a) (Type, Print) Morella 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b, perFH, G909, 11/12/2010, WS

State of Maryland / Department of Health and Mental Hygiene 22440 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** M. Jeane He Lopresti 6:10 AM July 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Multimedical Center 7700 York Rd. 21204 Towson, Maryland Baltimore 8. Date of Birth June 6 1917 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2√XF 93 Months Days Hours Min 218 03 9174 Baitimore, Maryland Director Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits 10c. City Town or Location Director Baltimore 1 X Yes 2 □ No Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 3552 Woodring Avenue LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify: Completed by Specify White 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (14or 5+) Elementary/Secondary (0-12) Housekeeping-Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dominic Pompa Dareen Cozzi ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace A Lopresti 3552 Woodring Avenue Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 2010 Baltimore, Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 21, Parkwood Cemetery 4 □ Donation 5 □ Other (Specify) June Signature of Funeral Service Licensee 22. Name and Address of Eacility
Lassahn Funeral Home Inc botton 3287 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia 7/13/2010 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner weeks to months Dysphagia Sequentially list conditions, Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Dementia monthstoyears attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Year 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive heart failure due to severe auctic stenasis 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? Severe arterial occlusive disease of right lower extremety 24a. Was an autopsy performed certificate 25. Was case referred to medical examiner? 1 ☐ Yes 2 🗆 No 1 ☐ Yes director Be 26. Place of Death (Check only one) 1□Yes 2⊡No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director; 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours are:

To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Nurse Practitioner: 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Michelle E. Kalendek, CRUP Genesis Multimedical Center 7700 York Road Towson, Maryland 21204

R097104

July 19, 2010

belle E. Kalende 4 CRUP

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22441 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUL Y LAYTON 18 2010 JACK JAY 5:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 218-03-5906 1 **XX**M 2 □ F Months Days Hours 10[%]30′/19′1″ 92 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10h Count 10c. City, Town or Location aţ 10d. Inside City Limits Director Examiner must be notified BALTIMORE MD **BALTIMORE** 1 Yes XX No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 23a 21208 7 SLADE AVENUE #103 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 XX Married 1 WYes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " AMERICAN COOPERAGE should be filed within 7 h and Mental Hygiene. 7 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the OWNER DRUM STEFL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SARAH DISMAN MORRIS LAYTON permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SLADE AVE; #103; BALTIMORE, MD 21208 FLORENCE LAYTON / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1)XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) INGTON CHIZUK AMUNO 7/18/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN RD: PIKESVILLE. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Hemorrha Physician/ ubarac hnoic Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (of as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ō Month Day Year Pregnant at time of death the detached g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signi page 2 should be 3 Probably 4 Unknown 1 🗌 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe No. Yes 2 1 Tes within 24 hours a er de.th.

To the Funeral Director: After this certifics completed filled | by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town. State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 0059470 Whan i, MO

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Kem 23a) (Type, Print)

32. Registrar's Signatur

emo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health and Mertificate of Death	1ental Hyg	iene _{eg. No.} 2010	22442				
	Di		Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death				
	Physicia Medic		ELIZABETH MEITZLER LEBHERZ		July	<u>16 2010</u>) 5:20A M				
	Examir	ner	4a. Facility Name (If not institution, give street and number) Lorien Mays Chapel	4b. City, Town, or Location of Death Timonium		4c. County of Dea Baltin					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 155–09–9799 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day,	9. Bir	thplace (State or Foreign				
	Director		155-09-9799 1 1 M 2XX F 93 Yrs.		November	22,1916 Mary	yliand				
	shov dat	ģ	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits				
	Mary 28a-f otifie	irec	Maryland Baltimore Baltimor	e			1 ☐ Yes 2 🕅 No				
	th the	Funeral Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?				
	ath wi	nuel	6009 Charlesmeade Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21212	aif. Van au Na	USA					
9	er deg or ite miner	by Fi	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 2 1 No	Was Decedent of Hispanic Origin? (Spei If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - Ame Black, White					
903	ırs aft ıra l", I Exal	edt	3 ☐ Widowed 4 XXXDivorced If Yes, Give Year or Dates.	1 ☐ Yes 2XX No Specify:		Specify:	White				
5-("2 hou "natu	plet		dent's Usual Occupation kind of work done during most of workir	ng	16b. Kind of Business	Industry				
12	ithin 7 ene. • than	Completed	College (1-4 of 5+)	oo NOT use retired) ctor of Education		State of 1	Maryland				
Q 7	Hygi Hygi other ent, t	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M		· di yidi d				
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	욘	Charles Elmer Meitzler	Annie Lea	, .						
lan	shoule and la is ma	15		ing Address (Street and Number or Rural			o Code)				
€,	and 2 lealth			Charlesmeade Road Balti							
Jor	Page 1 ament of hand of hand: If its			matory or other place)		20c. Location - City or					
ij	+ + =	1	21 Contain 5 ☐ Other (Specify) 21 Contained Funeral Sprvice Lice/See	1		Baltimore, Man	-				
Ba	Depar Impo any ir	17	Jennis Bysleng Onnikes	2. Name and Address of Facility Mitc 6500 York Road E	Baltimore,	Maryland 212					
	23a. Part 1. Enter the disease, or commiscations that caused the leath. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart failure. List only one cause on each line. Ph. sician/ The sician of the sician										
Andreadon,	Physician/ Medical	9 10	Immediate Cause (Final disease or condition resulting in death)	X Denuen	S		Onset and Death				
فعمرريا	Examiner		Due to (or as a consequence of):								
	c	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence or):								
	uted Id ansit	ami	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.								
	e exectian ar	dical Examiner	resulting in death) Last Due to (or as a consequence of):								
90	asth certificate be executed attending physician and for use as the burial-transit	gic	d								
687	ertific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy								
P.O. Box 687	eath c atten I for u	Physician/Me	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	Day Year				
<u>.</u>	the de by the achec	hys	9 Unknown								
<u> </u>	requires that the der been signed by the s should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?				
ds,	equire	ted			1 🗆 Ye	s 2 No 3 P	robably 4 🛆 Unknown				
O Q	law re has be e 2 sh	Completed			24a. Was an autops	y prior to o	topsy findings available completion of cause of				
Ä	sician: The law certificate has rector, page 2		25. Was case referred to medical		perform 1 \sum Yes 2	ned? death? No 1 \(\sum \) Yes	2 □ No				
/ita	Physician: T r this certifica rral director, p	8	examiner? Hospital:	26. Place of Death (Check							
oŧ/	ding Phy h. After this funeral d	e: To	27. Magner of Death 28a. Date of injury 28b. Time of	f 28c. Injury at 2		nce 6 Other (Spec	ify)				
on	ttending death. tor: Afte the fun	ficat	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work? M 1 ☐ Yes 2 ☐ No							
Division of Vital Records,	I or Attending after death. Director: After I in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,				
Ξ	pital or At ours after of eral Direc filled in by		200 0.75								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2	tigation, in my opinion, death occurred at t	the time, date and	place, and due to the	cause(s) and manner stated.				
	Voithi Com		29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month					
D			Stry, CAN'	R08021	0	1/16/	10				
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 2189 ST, Buil	£ 4/05	Balhman	x, Md 21204				
	Stat	6	31. Date filed (Month, Day Year) 2 0 2010 32. Registrar's Signature	ball		/					
	Registra	ır	JUL 20 2010 Leneur A.	and the same							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a, perFH, G905, 7/28/2010, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ^{Day}2010 Physician/ July Year David Lowenthal 12:03 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 709 Hampton Lane Baltimore <u>Towson</u> Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Davs Hours Min 1 XM 2 □ F Director 213-52-5693 Marvland Mav or 28a-f show 10a. State 10b. County death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🎇 No Maryland **Baltimore** Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21286 709 Hampton Lane U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. permit. Page 1 and 2 strough committee.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturany injury or other traumatic event; the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman <u> Gas & Electric Company</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jack Lowenthal Barbara Lee Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, Maryland Father 709 Hampton Lane <u> Jack Lowenthal</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dulaney remaior (varied)
Dulaney remaior prother place)
Memorial Gardens 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entanhment 7-22-2010 Timonium Maryland 21. Si mature of Foreral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Leans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine • Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.
• Funeral Director; After this certificate has been sinned by the attending abundant and the second of the second the burial-transi and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No page 2 should be detached for Dav g 🗌 Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury 1 🗌 Yes 2 🗒 No М Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie pleted cause of death (Item 23a) (Type, Print) Pd 2103

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

10-05286 Samuel Moore Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 22444

		1- For State Registrar			Certifi	icate of	Death		,	R	eg. No.	, , ,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Physic Medical Exam									2. Date of Death Month Day Year July 14, 2010 3. Time of Death 1305 hrs				3. Time of Death 1305 hrs
		4a. Facility Name (if not inst		eet and number)		4k	. City, Town, Essex	or Location		July 14, 2	4c. County		
Funeral		5. Social Security Number	6. Sex		(In yrs. last b	oirthday)	If Under 1 Y			8. Date of Bir	Baltimor	9. Birt	hplace (State or
Director	ı	220-78-6981	1 X M	2 F	0	Yrs.	Months D	ays Hour	rs Min.	2/17/	1960	Foreig Cou	MD untry)
any		Usual Residence of Decede 10a. State 10b. Cou]1	Oc. City, Tow	vn or Location	1						10d. Inside City Limits
ne Maryland or 28a-f show any fied at once,	ţ	MD Bal	timore	e	Esse	≥x							1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be notified at once.	Director		loodwa	rd Dr.			10f. Zip Code 2122			1	0g. Citizen of Wh USA	iat Coun	itry?
eath with items 2;	Funeral	11. Marital Status 1 Never Married 2	Married 12.	Was Decedent E Armed Forces?		13. Was	Decedent of I , specify Cub	Hispanic Ori an, Me xicar	igin? (Spec n, Puerto Ri	cify Yes or No can, etc.)	- 14. Race White		can Indian, Black,
after d "al", or	J. F.	3 Widowed 4	Divorced If Ye	s, Give Year	∑ No	1 Y	es 2 X	lo specify:	:		Specify:	Whi	te
2 hours "natur	ted	15. Decedent's Education (Elementary/Secondary (0-		ghest grade comp College (1-4 or 5+			Usual Occup t of working li				16b. Kind of Bu	siness/Ir	ndustry
036 vithin 7: ene. er than	Completed	12		5011 0 g0 (1-4-61-6)		lecha	nic				IIVAC		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Mid Hezekiah Mo									Maiden Surname)		
212 should b nd Meni is marl	70 E	19a. Informant's Name/Relat			1	9b. Mailing A	ddress (Str	eet and Nun	mber or Run	al Route Num	ber, City or Town	n, State,	Zip Code)
e, MD I and 2 sho Health and item 27 is		Stephanie M 20a. Method of Disposition	loore/I	Daugnte			Ounsmi	emetery	Г	late	20c Location	City or T	MD 21220
MOr Pages I nent of I ant: If		1 Burial 2 Crema 4 Donation 5 Othe		emoval from State	crema	atory or other			July 201	16,	Beltsv	i11	e, MD
Balti permit. Departn Imports injury o		21. Signature of Funeral Ser		p	101585	22. Nar	ne and Addre	ss of Facility	AFA/	Steph	en D.L	ohr	mann P.A.
Physician		23a. Part I. Enter the disease failure. List only one ca	, or complication	ons that caused th	e death. Do r	- 1.871	l7 Gre	en P	Pastu	res D	r Ral	to	MD 21286 Approximate Interval
/Medical Examiner		Immediate Cause (Final dise or condition resulting in deat	ase a. Hy	pertens		art Di	sease						Between Onset and Death
		Sequentially list conditions,	b	o (or as a conseq	uence of):								
	Examiner	if any, leading to immediate cause. Enter Underlying Car (Disease or injury that initiate	ise _	o (or as a consequ	uence of):								
ited d ansit	Exar	events resulting in death) La	st Due to	or as a consequ	uence of):								
3760, ficate be executed g physician and sthe bunial - transit	dical	X UNPENDED	AME	ENDED 1,2	3a,pt.	11,27	per me	g908	3 10-1	5-10 v	/t		
8760, ificate bong physical streets burners	n/Me	IF FEMALE: 23b. Was decedent pregnant		Live birth	of pregnancy	2 Fetal	٠١ 2	Ectopic			23d. Date of o	,	V
Box 68' e death certifi the attending ed for use as I	Physician/Medical	past 12 months?	4 [Unknown 9	Pregnant at tin	ne of death		(Specify)	Ectopic	c pregnancy		Month	Da	ay Year
O. B at the de il by the tached i		Part II. Other significant cor	9	Unknown ibuting to death b	ut not resultir	ng in the und	erlying cause	given in Pa	ırt I.	23e. Did tol	pacco use contrib	oute to th	ne cause of death?
S, P.O.	ed by	Chronic Al	coholis	5m								Proba	ubly 4 🗸 Unknown
cord	Completed									24a. Was a autops perforr	y pr		opsy findings available impletion of cause of
Vital Rec ysician: The his certificate director, page	e Co	25. Was case referred to med	ical				26 Plac	e of Death (Check only	1 ✓ Yes 2		Yes	2 No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospita	il: 1 Inpatient	2 ER/C	Outpatient 3		I Oak a se			Residence 6	Other:	Scene
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi			ending	Ba. Date of Injury (Month, Day, Year	28b.	Time of Injur	·	ury at Work?	- 1	d. Describe h	ow injury occurre	d	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 C	Juid not be	8e. Place of Injury	/ - At home, f	arm, street, f	actory, office	building, etc	c. 28f	. Location (St or Town, Sta		r or Rura	al Route Number, City
Di To the Hospital of within 24 hours a To the Funeral I		4 Homicide		Specify) the best of my ki	nowledge de	ath occurred	at the time of	ate and nla	co and due		·	ae etatos	
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical E	xaminer:On the	e basis of examin	ation and/or i	investigation	in my opinio	n, death occ	curred at the	e time, date a	nd place, and du	e to the	cause(s)
	Σ	29b. Signature and title of cen	itier	/		`	29c. Licens	M.E.	OCME		29d. Date signed July 15, 201		h, Day, Year)
2 Pener	-	30. Name and address of pers	on who comple	TR.	h (Item 23a)	0,							
		Theodore M. King,	r., MD. A	Assistant Med		iner 11	1 Penn St	reet, Bal	timore, N	/ID 21201			
Sta Regist		or. Date filed (Modify),	4111	32. Agistrar's	signature .	Span	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State o	f Marylan	d / Depa <i>Cer</i>	artment of tificate of	Health Death	and M	1ental Hy	giene ,	2010	22445
Physic Med		1. Decedent's Name (First, Middle Edward Clay	_{e, Last)} Maxwell						2. Date of De Month July		Year 2 0 1	3. Time of Death 1:10 PM
Exam		4a. Facility Name (if not institution 1119 Stephen		ber)		4b. City, Town, Middle				4c. C	County of Death	1
Funera Directo		5. Social Security Number 217–26–2303	6. Sex 1 M 2 □ F	7. Age (In yrs. la 86	ast birthday) Yrs.	If Under 1 Year Months Days			8. Date of Bi	rth	9 Rintl	nplace (State or Foreign ntry) MD
aryland a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Balt	imore		y, Town or Loc							10d. Inside City Limits 1 ☐ Yes 2 📈 No
ith the M 3a or 28 it be noti	ral Dir	10e. Street and Number 1119 Stephen	Dr			10f. Zip Code					en of What Cou	•
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Deced Armed For 12 Yes	2 ∐ No	l1	Vas Decedent of Yes, specify Cub	an, Mexicar	i, Puerto f	cify Yes or No- Rican, etc.)	USA 14	4. Race - Amer Black, White	
Maryland 21215-0036 2 should be filed within 72 hours after alth and Mental Hygiene. 27 is marked other than "natural", o	Completed	3 Widowed 4 Divorced 15. Decede (Specify only high	If Yes, Give Year or Dat nt's Education est grade completed)		16a. Deced	lent's Usual Occu	pation		20		becify:Whi d of Business In	
2121 I within 7 ygiene. her than it, the Me		Elementary/Seconday (0-12)	College (1-	4 or 5+)	life. DO	NOT use retired)	OI WOIKII		Fact	ory	
yland Id be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, I Harry Clay M	axwell				Len	a So	(First, Middle,	er	ŕ	
, Maryl nd 2 should I saith and Me n 27 is marl er traumati		19a. Informant's Name/Relations Marylin Caro	n ^{ip (Type, Print)} Dau l Petro/	ughter	19b Mailin 11119	g Address (Street Stephe	and Numbe	er or Rural	Route Number	er, City or To Rive	own, State, Zip r, MD	^{Code)} 21220
Baltimore, permit. Page 1 and Department of Heal Important: If item 3 any injury or other pace.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5	3 ☐ Removal from S	State C6	emetery, crem	sition (Name of patory or other pla ake Cre	ce)	July 201	20,	20c. Loca Belt	ation - City or T ${ t svill}$	own, State
Balti permit. Departr Imports any inji		21. Signature of Funeral Service L	declora	Mo	1585 22	Name and Addre	ess of Facilit	CAF	1/Step	hen	D.Lohr	mann P.A.
Physician, Medica Examine		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (o	th line. ARY eque	ence of):	r the mode of dyi		0		rest,	ertis	Approximate Interval Between Onset and Death
760 ate be executed only sicial atterval the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	r as a conseque								
760 cate be execute physician and sthe burial-trans	ledical		d									
Kecords, P.O. Box 687 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 D Fetal ant at time of de	death 3	Ectopic pregnan Other (specify) _	су			23	d. Date of deliv	very Day Year
Division of Vital Records, P.O. By To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the accompleted filled in by the funeral director, page 2 should be detached	ted by Ph	Part Ot or significant condition	ns contributing L dea	at but not resu		derlying cause g					contribute to t	he cause of death?
Kecords, The law requires cate has been sig									24a. Was autop perfo 1 Yes		24b. Were auto prior to co death? 1 ☐ Yes	psy findings available impletion of cause of
VITAI hysician: his certific al director,	To Be	25. Was case referred to medical examiner? 1 Yes No		npatient 2 🗆 E		Oth	lace of Deat er: 4 □ Nu			dence 6	Other (Specify	<i>(</i>)
ilon of tending Pt leath. tor: After th the funeral	Certificate:	27. Manner of Death 1	ation	, Day, Year)	28b. Time of injury			- 1	8d. Describe h	ow injury or	ccurred	
DIVISION ital or Attendin urs after death. ral Director. Aff lled in by the fur		4 Homicide determi	ned 28e. Place o building	g, etc. (Specify)		et, factory, office			City or Tow	n, State)		l Route Number,
the Hosp thin 24 hor the Fune	Medical	only one) Certifying	Physician: To the best familier: On the basis Nurse Practioner: To	of examination a	and/or investi	gation, in my opini eath occurred at th	on, death occ e time, date	curred at t	he time, date a , and due to the	nd place, an e cause(s) ar	nd due to the ca	use(s) and manner stated. ated.
5 ≥ 6 0		29b. Signature and title of certifier	Same	· un		29c. Licens	e number	26		29d. Date s	signed (Month,	Day, Year)
(No.		30. Name and address of person v	hocompleter cause				altin	्राट	MD a	21236	1	, , , , _ _
Sta Registr		31. Date filed Manth Day Year	32. Reg	istrar's Signatu								

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			1 - For State Registrar	State of Marylar	nd / Depa <i>Cer</i>	artme tifica	nt of H	ealth ar Death	nd Me		20 I	0	2241	+6
	Physici	an	Decedent's Name (First, Middle, Last)	000 121-0					2	. Date of Death Month	Day	Year	3. Time of D	
1	/Medio		AL BERTA 4a. Facility Name (If not institution, give s	MCKEE		4b. Cit	y, Town, or	Location of I	Death	06	4c. County	of Death		1 101
	LXaiiii	CI	Future Care - Hom				ltimo				,			
	Funeral Director		5. Social Security Number 6. Sex 212-22-2971	7. Age (In yrs. 83	last birthday) Yrs.	If Und Month	er 1 Year S Days	If Under 24 Hours	Hrs. 8	Date of Birth (Month, Day,)	(ear) 127	9. Birth Cou	piace (State or untry)UNK	Foreign
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ity, Town or Lo	cation							10d. Inside City	Limite
	Maryle f aho	or	MD 100. County		altimor								13€ Yes 2	
	r 28a-	rect	10e. Street and Number		arcimor		ip Code			100	. Citizen of W	/hat Cou	untry?	
	th with	aiD	2700 N. Charles	Street			21218				USA			
920	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23s or 28s-f ahow any injury or other traumatic event. Its Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in L Armed Forces? □ Yes 2 ☑ No If Yes, Give Year or Dates:	It	fYes, sp	edent of Hisecify Cubar	spanic Origin n, Mexican, I Specify:	n? (Speci Puerto Ri	ly Yes or No- can, etc.)		k, White		
ပို	72 hou	ted	15. Decedent's Educ	cation	16a. Deced	lent's Us	ual Occupa	tion unk		16	ib. Kind of Bu	sıness/lı	ndustry unk	
21	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT	use retired)	uring most o	or working					
2	ited w Hygier ther th		unk 17. Father's Name (First, Middle, Last)	unk				10 Mathada	- No //	First, Middle, Ma	idea Cuman	-) 41-0	1-	
and	d be t ental l	To Be	17. Facility S Ivaling (First, Mildule, Cast)	unk				TO. MOUTERS	S Name (™st, Middie, Ma	iden Sumami	3) UII.	.K	
Maryland 21215-0036	shou and M mar	-	19a. Informant's Name/Relationship (Typ	pe, Print)						Route Number, (
Σ	and 2 salth a n 27 li		Future Care - Hom	newood	270	00 N	. Chai	rles S	tree	t; Balt:	imore,	Mar	yladn 2	1218
Baltimore,	Pages 1 nent of Ho int: if Iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☑ Other (Specify)	emoval from State	Place of Dispos cemetery, crem	sition (N natory o	ame of other place	9)	Dat	e 20	c. Location -	City or T	Fown, State	
Balt	permit. Depertr Importa any inju		21. Signature of Funeral Service I centa	Directo						d; 655 V d 21201	V. Balt	imo	re Stre	et
			23a. Par 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the dear	th. Do not ente	er the m	ode of dying	, such as ca	ardiac or r	espiratory arres	t,		Approximate Interval Between	een
1	Physician		Immediate Cause (Final disease or condition resulting in death)	netaslata	. In	~9	Come	ع					Onset and De	atn
	/Medical Examiner		resulting in death)	Due to (or as a consecuence Careboo va	quence of):	,		0 . 1						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):		acu	aen	~					-
	cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	strial	Fubril	lal	-							
Ö,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):		4	0 0					·	
8760,	icate be executed physicien and s the burial-transit	dicai	d.	Umme	obs t	マルロ	tre	Puln	ma	y Di	eeal	-		
	death certif e ettending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. If yes, outcome of pregni 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 🗆	Ectopic Other (pregnancy specify)				23d. Date Mor		very Day Ye	∍ar
J.	thet the ad by th detach		Part II. Other significant conditions conf	ributing to death but not res	sulting in the un	derlying	Called Give	n in Part I		23e Did toba	cco use contr	ibute to	the cause of dea	ath?
Vital Records,	iaw requires thet the es been signed by th 2 should be detache	d by	<u> </u>			_	3					3 🗆 Pro		_
<u>ဂ</u>	law requir ss been si 2 should I	Completed								24a. Was an	24b. V	Vere aut	topsy findings av	vailable
ř	The ete h	Com							_	autopsy performe 1 Yes 2 €	d?_ d	eath?	ompletion of cau 2 No	use of
/Ita	iician: Th certificete rector, paç	Be (25. Was case referred to medical examiner?					26. Place of	f Death (Check only one				
ō	Phys this	- T	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient	3 🗆 🗈		4 Nursi	7	5 Residen			cify)	
o	ding th. : After fune	tion	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	М	28c. Injury Work 1 □ Y	ai ? ′es 2∐No		d. Describe how	injury occurr	,u		
Division	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	et, facto				Location (Stre City or Town,		r or Rui	ral Route Numb	er,
	= 0	edical C	29a. Certifier (Chark only one)	cian: To the best of my knows: On the basis or examination and manner stated.	owiedge, death allon and/or inv	occurre	d at the time in, in my op	e, date and p inion, death	place, and occurred	d due to the cau at the time, date	se(s) and mai and place, a	nner as	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier			2	9c. License	41		290	l. Date signed			
					MD		D:	31 46	4		318	110	•	
			30. Name and address of person who cor					6: 0	~ 0	3001				
	Sta	0	31. Date filed (Month, Day, Year)	MI MD 3-21 32. Registrar's Signa	N. ET	MIA	TW .	27 8	mte	308 13	ALTI	non	EMD	2120
I	Registra		JUL 2 V 20	10 Sener	A. A	and the								

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Amend # 9.11.15-16 b. 10a-22 per In 905 //21/10 TI

amend #5 Per FH G908 10/20/10 Jh

Certificate of Death

Reg. No. 22447 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 MCKINNEY 0253 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 218-50-8669 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. Sept 5, 1950 South Carolina **Director** 59 Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a -f shov aumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21045 9430 N. Pennfield Rd. USA nit. Page 1 and 2 should be filed within 72 hours after death vartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?unk Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working unk life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Counter Agent Airlines unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a Informant's Name/Relationship (Type, Print)

ROCCI Nykylorciyn 199490 N. dd res Girte 1d Nachdor Collembia, My it 21045, State, Zip Code)
5755 Gedar Lane; Columbia, Maryland 21044 Howard County General Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Tother Specify 111 State cemetery, crematory or other place, emation, Inc. 7/19/10 Hanover, MD

2 State Anachiny Board; 655 W. Rolfimore Harford Road Ardent Cremation, Inc. Signatur of Funeral Serviced centre Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYO CARDIAL
To (or as a consequence of): Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Yes 2 No the 9 Unknown P.O. signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERUPIDEMIA Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform 2 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After the completed filled in by the funer. 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of redman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. DRIVE, COLUMBIA, MD 21045 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22448 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JULY 2010 3:35 AM Physician/ **NEUHAUS** MARGERY Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE NORTH OAKS HEALTH CENTER 8. Date of Birth g. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 🗆 M 2 🕱 F 12709/1916 93 214-18-2923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 23a or 28a-f shorst be notified at 10a. State Completed by Funeral Director 1 Tes 2 X No PIKESVILLE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 21208 725 MT. WILSON LANE, #314 permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner myone. 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🗱 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 X Widowed 4 Divorced 16b, Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ္ ROSENBUSH EDITH BLUM HENRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 74 REGENTS PARK, WESTPORT, CT SUSAN KING/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State REISTERSTOWN, MD BALTIMORE HEBREW CEM | 07/18/2010 4 Donation 5 Other (Specify) of Funeral Service SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one can see on each line. Approximate Interval Between Onset and Death Immediate Cause (Final up heceptic 10000 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) Pregnant at time of death a I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ♣No 3 ☐ Probably 4 ☐ Unknown 1 Yes Division of Vital Records, peen About Failing to thruis 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has performed 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\begin{center} \begin{center} \text{Other} \\ \text{Other} \end{center} \) ALF 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 은 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: s after death. I Director: After t work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be completed filled in by determined within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1737513 16, 2010 opleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co MD 71707 2835 Zkell MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

20

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 22449 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ JULY 17, 2010 Jerome Thomas O'Meara 8:35P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Long Green Baltimore None **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 XX 2 F Months Days Hours Sept 11, 1924 Director 212-20-6948 85 Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 XXNo baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 225 Dunkirk Raod 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

Yes 2 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: White 3 XXWidowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Construction Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ |Edward James O'Meara Dora Schwamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon O'Meara Boynton DTR 1382 Heathescreek Court Englewood Florida 34223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State July 24,2010 | Pikesville, Maryland Druid Ridge Cemetery 4 Donation 5 Other (Specify) nature of Fuperal S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or com shock, or heart failure. List only c lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Immediate Cause (Final YEAZS ATHOROSCLEROTIC CARDIOVASCULAR DISEASE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). Exami the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Month Day Year signed by the a 1 Yes 2 9 Unknown Yes 2 No Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 - No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated working Nurse Practioner: To the basis my knowledge at the line, date and place, and due to the cause(s) and manner stated working Nurse Practioner: To the basis my knowledge at the line, date and place, and due to the cause(s) and manner stated (Check only on 29b. Signature ar

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

031136

9005 KICBRIDE LD., BALTIMORE, MD 21236

10-05232 Gerald Peck Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gerald Peck, Jr	.	State of Maryland 1- For State Registrar	/ Department of Certificate of		nd Mental I		20 eg. No.	10 2245
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Gerald Lee Peck, Jr.				2. Date of Deat Month July 12, 20	th Day Year	3. Time of Death 0931 hrs
		4a. Facility Name (if not institution, give street and number St. Agnes Hospital)	4b. City, Town, o	or Location of Dea		4c. County of D	eath N/A
Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 M 2 F	ge (In yrs. last birthday) 30	If Under 1 Ye Months Da			th(MM/DD/YYYY) 9. 7, 1980 Fo	Birthplace (State or reign MD
Aaryland 28a-f show any Latonce,	Director	Usual Residence of Decedent 10a. State	10c. City, Town or Loca	ation Halethori 10f. Zip Code	-	10	Dg. Citizen of What C	
5-0036 led within 72 hours after death with the Maryland thygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at ones.	by Fun	11. Marital Status 1 X Never Married 2 Married Armed Forces	? If If If If If If If If If If If If If	Vas Decedent of H Yes, specify Cuba Yes 2 X N ent's Usual Occup most of working life	o specify: ation (Give kind of	to Rican, etc.)	White, etc	nerican Indian, Black, hite
	S Completed	12 17. Father's Name (First, Middle, Last)		Laborer		ne (First, Middle, M	laiden Surname)	truction
O tigging all	To Be	Gerald Lee Peck, Sr. 19a. Informant's Name/Relationship (Type, Print)			et and Number or		ber, City or Town, St	
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and I important: If iten 27 is rinjury or other traumatic.		Susan Pack - Mother 20a. Method of Disposition 1	20b. Place of Dispo crematory or o Cedar Hi	osition (Name of conther place). 11 Cemet	ery July	Date 19,2010	20c. Location - City Glen Bur	or Town, State
Physician	d	23a. Part I. Enter the disease, or complications that caused	2	2719 Hamm	onds Fry	Rd., La	ınsdowne,	
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a conse			,, 545, 45 54, 45	or respiratory dire	or, shook, or real	Between Onset and Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
50, te be executed ysician and burial - transit	EX	events resulting in death) Last Due to (or as a conse	equence of):					
60, ate be ex hysician e burial	Nedical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcon	me of pregnancy				22d Date of delic	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fe	etal death 3 Other (Specify)	Ectopic pregn	ancy	23d. Date of deliv Month	Day Year
S, P.O. uires that the n signed by d be detach	è	Part II. Other significant conditions contributing to death	n but not resulting in the i	underlying cause	given in Part I.			to the cause of death?
tal Record cian: The law req certificate has bee	Completed	25. Was case referred to medical		00.01		24a. Was ar autops perform 1 Yes 2	y prior to ned? death1	autopsy findings available completion of cause of Yes 2 No
Vital hysiciar this cer	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatien	nt 2 ER/Outpatient		of Death (Check Other Nursir		esidence 6 Ott	er,
ion of ttending Pl leath. tor: After t the funera		27. Manner of Death 1 Natural 5 Pending Jul 1, 2010 2 Accident Investigation	ry 28b. Time of I 0000 hrs	· · ·	ry at Work? Yes 2 ✓ No	28d. Describe ho Subject hang	ow injury occurred ed self	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Certification:	3 Suicide 6 Could not be determined (Specify) Sing	iury - At home, farm, stree gle Family	et, factory, office b		or Town, Sta		Rural Route Number, City
To the Ho within 24 F To the Fu	edical	29a. Certifier (Check only 2 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examand manner stated.		ition, in my opinion	i, death occurred a			
		29b. Signature and title of certifier Pamel Fouthauli mis		29c. Licens			29d. Date signed <i>(N</i> July 14, 2010	lonth, Day,Year)
		30. Name and oddress of person who completed cause of de Pamela E. Southall, MD Assistant Medic	cal Examiner 11	1 Penn Stree	t, Baltimore, N	/ID 21201		
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar	's Signature	wild				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July Day 2010 2:30 P M DORIS MARY PAYNE 16 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 6 Pequot Court Bel Air Harford Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Funeral 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) Days 1 🗆 M 2🔀 F Hours Director 7-22-1092 Maryland June 8 10a. State 10b. County 10c. City, Town or Location must be notified at Director 28a-f Maryland Bel Air Harford 1 ☐ Yes 2 🛂No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 USA 6 Pequot Drive and 2 should be filed within 72 hours after death "natural", or item edical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Completed by 1 Never Married 2 Married Yes 2 No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Company Packager Packaging Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ပ Thomas James Ryan Martha M. Strecker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6 Pequot Court, Bel Air, Maryland 21014 Health a Phyllis M. Sheridan / Daughter Department of Health Important: If item 2: any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cemetery 7-20-10 Baltimore, Maryland Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ una Carcinoma disease or condition Medical resulting in death) Due to (or as me insequence of). **Examiner** Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of,: burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law voyanthin 24 hours after death.

othe Funeral Director. After this certificate has been significate has been significate has been significated. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 2 🛂 N 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🛂 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) completed filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. I Division of Vital Records,

within To the State Registrar

Medical

29a. Certifier

(Check only one)

CEONARD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARDSON M.D.

M.D.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

1838 GREENE TREE ROAD #300 PILESVILLE MP 21208

2010

29c. License number

The Johns Hopkins Hospital The Johns Hopkins Holpinal College Here The Johns Hopkins Holpinal College Here The Johns Hopkins Holpinal College Here The Johns Hopkins Holpinal College Here The Johns Hopkins Holpinal College Here The Johns Hopkins Holpinal College Here The Johns Hopkins Holpinal College Here The Johns Hopkins Holpinal College Here The Johns Hopkins Holpinal College Here The Johns Hopkins Here The Johns Hopkins Holpinal College Here The Johns Hopkins Here The Johns Hopkins Here The Johns Hopkins Here The Johns Hopkins Here The Johns Hopkins Here The Johns Here The Johns Here The	3. Time of Death
The Johns Hopkins Hospital The Johns Hopkins	
10a. State 10b. County 10c. City, Town or Location 10c. City or Inc. Inc. Inc. Inc. Inc. Inc. Inc. Inc.	n/a 9. Birthplace (State or Foreign Country) MD
William Edward Purvis 19a. Informant's Name/Relationship (Type. Print) Henrietta Purvis—Wife 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21 Screen of Europa Service (Mensale P) 22 Name and Address of Eacility 23 Name and Address of Eacility	10d. Inside City Limits 1 Y Yes 2 □ No
William Edward Purvis 19a. Informant's Name/Relationship (Type. Print) Henrietta Purvis—Wife 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21 Screen of Europa Service (Mensale P) 22 Name and Address of Eacility 23 Name and Address of Eacility	USA Race - American Indian, Black, White, etc.
William Edward Purvis 19a. Informant's Name/Relationship (Type. Print) Henrietta Purvis—Wife 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21 Screen of Europa Service (Mensale P) 22 Name and Address of Eacility 23 Name and Address of Eacility	of Business/Industry le Fruit Sales
1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carrison Forest VA Cem 7.20.2010 Owing 22 Name and Address of Facility	,
4 Donation 5 Other (Specify) Garrison Forest VA Cem 7.20.2010 Owing	
451 / Park Hote Ave Baltimore MI	gs Mills, MD
23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician / Medical Examiner Due to (or as a consequence of):	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
Solution of the past 12 months? 1	d. Date of delivery Month Day Year
The significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use (contribute to the cause of death?
24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{Mas}\) and autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No}\) and autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No}\) And a \(\text{No}\) and autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No}\) And a \(N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) 1 Aursing Home 5 Residence 6 Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury one	Other (Specify)
1 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes Yes 2 Yes	Number or Rural Route Number,
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29b. Signature and title of certifier 29c. License number D0035468 29d. Date signature	igned (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, I State Registrar 31. Date filed (Month, Day Year) 20 2010 August 4. August 84. August 10 20 20 20 20 20 20 20 20 20 20 20 20 20	D. II' MD. 04007

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State Registrar	Maryland / Depa	artment of H tificate of D			iene _{eg. No.} 201	0 22453
	Physicia		Decedent's Name (First, Middle, Last) May Raila				2. Date of Death Month July	h □9 20	3. Time of Death 10 5:30 PM
	Medic Examin		4a. Facility Name (if not institution, give street and numb Gilchrist Hospice	per)	4b. City, Town, or Towson	Location of Death		4c. County of D	
~*	Funeral Director			7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth May 1, Day	g.	Birthplace (State or Foreign Country) ary Land
			Usual Residence of Decedent				may 1, 1	923 FI	
	laryland 3a-f sho ified af	Director	10a. State 10b. County MD Baltimore	10c. City, Town or Lo Parkvil					10d. Inside City Limits 1 Yes 2 No
	a or 28 be not		10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wha	t Country?
	ath witl	Funeral	8800 Walther Blvd; Apt 11. Marital Status 12. Was Deced		21234 Was Decedent of His	spanic Origin? (Spa	ecify Yes or No-	USA L14 Page - A	American Indian,
900	urs after dea ural", or ite I Examiner		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 ☑ Widowed 4 ☐ Divorced Year or Dat	ces? 2½ No	f Yes, specify Cubai	n, Mexican, Puerto	Rican, etc.)		Vhite, etc.
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4)	(Give life. D	dent's Usual Occupa kind of work done d O NOT use retired) 1Ca t or	ation luring most of work	ing	16b. Kind of Busin	
Maryland 2	be filed wental Hyg rked othe	To Be	17. Father's Name (First, Middle, Last) Henry Herman Tripp				e (First, Middle, M Katherin		
Aary	should and M is mar raumat		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a				, Zip Code)
re, N	l and 2 f Health item 27 other t		Wayne Raila - son 20a. Method of Disposition	20b. Place of Dispo				02139 20c. Location - City	y or Town, State
Baltimore,	. Page tment o tant: If jury or		1 Burial 2 Cremation 3 Removal from 5 Donation 5 Other (Specify)	State cemetery, crer	natory or other place	θ)			
Ball	permit Depart Impor any in		21. Si , atu e of Funeral Price Licensee ROD d S Ward Di	rector		atomy Bo			more Street
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	Medical Examiner			r as a consequence of):	1000				
	sit d	niner	cause. Enter Underlying	r as a consequence of:					
	icate be executed g physician and is the burial-transit	dical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	r as a consequence of):		_			
3760	ficate be g physic as the b		d			-			
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/M	in the past 12 months?	ant at time of death 5	Ectopic pregnance Other (specify)	у		23d. Date of Month	f delivery Day Year
s, P.O.	requires that the de been signed by the should be detached	d by Pr	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob		e to the cause of death?
ords	w requii s been 2 should	Completed					24a. Was an	24b. Were	autopsy findings available to completion of cause of
Bec	Physician: The law r this certificate has aral director, page 2 s	Com	25. Was case referred to medical				perform 1 Yes 2	ned? deat	
Vita	lysiciar is certif directo	To Be	examiner? Hospital:	npatient 2 - ER/Outpatier	Otho	ace of Death <i>(Chec</i> r: 4 Nursing Ho		nce 6 Other (S	pecify) WSRU
on of	nding Phath.: After the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	f injury , Day, Year) 28b. Time of injury	work	at	28d. Describe hov		
Division of Vital Records,	al or Atte s after dea I Director d in by th	Certificate:	3 Suicide 6 Could not be 28e. Place of	of Injury - At home, farm, strong, etc. (Specify)	eet, factory, office		28f. Location (Str City or Town,		Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the besis	of examination and/or invest	tigation, in my opinio	n, death occurred a	the time, date and	d place, and due to	the cause(s) and manner stated.
	To t With To t		29b. Signature and title of certifier All All All All All All All All All Al		29c License	pumber 8303	29	ad. Date signed (M	onth, Day, Year) 2010
			30. Name and address of person who completed cause	of death (Item 23a) (Type, F	G701 7	v-Che	ences s	T TW	anhorn
	Stat Registra		31. Date filed (Month, Day, Year) 32. Rep. 32. Rep. 32. Rep. 32. Rep. 32. Rep. 32. Rep. 33.	gistrage Signature	bare	,			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 0 1 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month RIDOLE LUTHER JULY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Levindale Nursing & Rehabilitation Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Days Hours Min. | 6. Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□1 Months Days May 27, Director 375-18-5964 91 New Jersey Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10b. County MD Baltimore tX Yes 2 No Director filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 2434 W. Belvedere Avenue 21215 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 N Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 law enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Luther Riddle Sr. Dorothy Potter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health an Important: If item 27 is any injury or other trauonce. Artie Shaw - guardian 10 N. Calvert St #300; Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in State 21. Signatur of Funeral Service Licensee Renal 1 S. Wada Wargctor 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) **Physician** ADVANCED DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Jonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an s certificate has bilirector, page 2 s autopsy performed' or Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 propatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

Neral Director: 4
filled in by the fi 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after or To the Funeral Direct 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D 68394 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDALE 2434 W. BELVEDERE AVENUE BALTIMORE MD 21215 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19b per SAB G905 7/23/10 dk

State of Maryland 7 Department of Health and Mental Hygiene

AMEND ITEM#5,11,12,15-20c,22perFH,G905,7/23/10,WS

Reg. No. 2010 22455 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 7:05 PM M Marjorie Ryan July 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
| FUnder 1 Year | | FUnder 24 Hrs. | 11823 Tenbrook Court Montgomery 8. Date of Birth (Month, Day, Jan 15, 5. Social Security Number Un 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) unk **Funeral** Months Days Hours Min. 1 □ M 21 F 88 Yrs Director 577-22-9492 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at MD Silver Spring 1 ☐ Yes 2 No Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or a may injury or other traumatic event, I're Medical Evantres must be an any injury or other traumatic event, I're Medical Evantres must be anone. 20902 USA Completed by Funeral 11823 Tenbrook Court 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupatio 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk 12 -unk-Office Manager 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ဂ Blanche Gallant Joseph Rhodes

19a. Informant's Name/Belationship (Type. Print) Personal

19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code)

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19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State)

19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State)

19c. Mary Land 20850

10253 Gainsborourg Rd Potomac, Mary Land 20854

20b. Place of Disposition (Name or cemetery, crematory or other place) Joseph Rhodes Harry L. Herrick, Jr. 20a. Method of Disposition rematory, Inc 7/19/10 Baltimore, Maryland

22. Name and Address of Facility Cremation Society of Maryland, Inc 29 Frederick Road Baltimore, Maryland 21228

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2. N 4 □ Donation 3 20ther (Specify) in 6tate Metro Crematory, Inc Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. shock Immediate Cause (Final disease or condition resulting in death) **Physician** ME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) P.O. I signed by the a 1 □Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perforn certificate 1 ☐Yes 2 ☐No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 35400 C ~ mo OmE 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 584 Faw 177 7 7 18. N. BREHER MO DME 5/1vc(Spring) 20. 21. Date filed (Month Pay Year) 32. Registrate Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 02010 Denem B. Sparker Registrar

DHMH 17 Rev 1/2001

OHIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ mms rma Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Paltimore atonsville NUISING 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 XiYes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral or items within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give "natural", 3 X Widowed 4 □ Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Specify only highest grade completed) (Give kind of work done during most of working Balto. City Menta permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) ount 22. Name and Address of Fallity To seph L. Russ 1222 W. North Si snature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEROSCLEROTIC ARDIOVASCUL Onset and Death Ph_sician/ DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (of as a collisequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ☐ Yes 2 🗓 No 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Pay II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HRTERY DISEASE 1 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown DUSPHACTA 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? certificate has autopsy performe 2 1 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death_(Check only one) Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 285 10 111

Registrar

State

mi

32. Registrar's Signature

BALID MD420

SUITE 203

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKHAMI

31. Date filed (Month, Day, Year)

20201

10-05321 Charles Leslie Smyth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 state of Maryland 90 bepartment of Health and Mental Hygiene 2010 22457

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State of Maryland / Department of Health and Mental Hygiene 2010 22458

	1- For State Certificate of Death Reg. No.											
Physic		Decedent's Name (First, Midd									3. Time of Death	
Medical Exam	ııneı	John Kussell	Sandy					July 12,	2010			0646 hrs
		4a. Facility Name (if not institution Johns Hopkins Bayvie		r)	4	• • • • • • • • • • • • • • • • • • • •	r Location of Dea	ath	4	4c. County of	f Death	
_		5. Social Security Number				Baltimore	Tan			N/A		
Funeral Director				ge (In yrs. last	t birthday)	If Under 1 Yea		in. 8. Date of b	Birth (MN	M/DD/YYYY)	Foreia	hplace (State or n
Birector		213-34-6748	1 <u>XX</u> M 2 F	73	Yrs.				27,	1937	Co	^{untry)} Maryland
any		Usual Residence of Decedent 10a. State 10b. County		Inc. City To	own or Location	n .						
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ith the 23a o notifi	E 0	842 West 35th S				21211				nited		
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5-0036 led within 72 hours after Hygiene, other than "natural", the Medical Examiner	g	15. Decedent's Education (Spe	or Dates:	mpleted) 16		Yes 2 No	tion (Give kind o	f work done	116h	Specify: Kind of Bus		ite
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336 thin 7 re. than edica	혈	6 years			Cab Dr	cirror			m-			
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21215-0036 ould be filed within 7 Mental Hygiene. s marked other than ic event, the Medica	4	Samuel D. Sandy	,			ľ	Anna E	. Weinma	nn			
221 hould nd Mer is man	ို	19a. Informant's Name/Relations			19b. Mailing	Address (Stree	et and Number of	Rural Route Nu	mber, (City or Town	State,	Zip Code)
MD and 2 she lealth and tem 27 is		Shirley Sprague	(Sister) 1		oe Driv		mpa, Flo	orid	la 336	15	
ore, MC es 1 and 2 s of Health at If item 27		20a. Method of Disposition 1 Burial 2 X Cremation	2 Demond from S		ce of Disposit	ion (Name of ce	metery,	Date		Location - 0		Town, State
Baltimore, MD 2 bernit. Pages 1 and 2 shou Department of Health and N important: If titem 27 is nijury or other traumatic		4 Donation 5 Other Sp				erv. Cor	7/	27/2010	m-		Ma.	1 1
Baltimo permit. Page Department Important: injury or ott		21 Signature of Funeral Service	Licensee		22. Na	me and Address	s of Facility					
i i i i i i i		Jan 1	11-60	W/	Dud	la-Ruck	Funeral Avenue	Home of	Du	indalk	, In	nc.
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that caused	the death. Do	o not enter the	mode of dying,	such as cardiac	or respiratory a	rest, sh	ock, or hear	t	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease	0 1: 1:	of Blunt Fo	rce Injurie	s						Between Onset and Death
LXammer		or condition resulting in death) Due to (or as a consequence of):										
	L	Sequentially list conditions,	b									
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of):							yo	
W	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):								
execute F an and al - transit	alE		d									
ਹ ਜ਼ੋਵ	ledical	UNPENDED	AMENDED									
760, ficate be g physic the bur	₹	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcome	ne of pregnan	_	. [23	3d. Date of d	•	
certii	ciar	past 12 months?	I LIVE DITTI	time of death			Ectopic pregr	ancy		Month	Da	ay Year
Box 68 death certi the attending	Physician	1 Yes 2 No 9 Unk	nown 9 Unknown		⊃ Othe	er (Specify)						
, P.O. Box 68 res that the death certif signed by the attending be detached for use as		Part II. Other significant conditi	ons contributing to deat	h but not resul	Iting in the un	derlying cause g	iven in Part I.	23e. Did (obacco	use contribu	ite to th	ne cause of death?
P.O.	ğ							1Ye	s 2	/ No 3	Proba	ibly 4 Unknown
Records, The law requir ficate has been s	Completed							24a. Was				ppsy findings available
COI law has b	d							auto perfo	psy rm <u>ed</u> ?		or to co ath?	mpletion of cause of
tal Rection: The certificate ector, page		05 W						1 Yes	2 N	lo 1	/ Yes	2 No
ital	å	25. Was case referred to medical examiner?	Hospital: 1 Inpatie		VOutpatient		of Death (Check Other Nursi		-	•□		
Phys er thi	٤	1 Yes 2 No 27. Manner of Death	28a. Date of Inju		b. Time of Inju		y at Work?	ng Home 5			Other:	
n of iding Pl h. : After e funera	ë	1 Natural 5 Pend	(Month Day Y	ear) 03	359 hrs	· I	y at vvoik? ′es 2 ✓ No	Subject bea		ury occurred		
ivision or Atteno after death Director:	g		tigation					000				1.B. (N)
Division of Vital tal or Attending Physician: 15 after death. al Director: After this certiled in by the funeral direction	Certification:	deter	28e. Place of In		, tarm, street,	ractory, office b	uliding, etc.	or Town,	State)			al Route Number, City
Ospital hours a uneral ly filled		29a. Certifier	(-000-0)					3500 Block o				
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral Sirector. page 2 should be detached for use as the buni	ica	(Check only	ysician: To the best of m niner:On the basis of exa									
To To con	Medical	290 Signature and title of certifier	and manner stated.			29c. License						h, Day, Year)
		1/2/2/	2 111			O.C.N				/ 14, 2010		,
		30. Name and address of person	who completed cause of a	eath (Itam 22-	2)					, , 2010		
5			ssistant Medical Exa		•	Street, Baltim	nore, MD 212	201				
	ate		32. Registra									
Regis	rar	31. Date file (Mog , 02010	Clerina	38 24	2000							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day Year 2010 Paul Andrew Stone

1:30 RM

Medical Examiner

4a. Facility Name (if not institution, give street and number)

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical **Examiner**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

er	4a. Facility Name (if	not institution, give s	street and number)		4	4b. City, Town, or	Location of I	Death		4c. County	of Deat	th
	Gilchr	rist Cente	r for Hos	spice Car						Bal	Ltin	nore
	5. Social Security N		x 7. Ag	e (In yrs. last birth	- N	If Under 1 Year Months Days	If Under 24 Hours		ate of Birth Aonth, Day, Y	(ear)		thplace (State or Foreign
	219-82	<u>-3570</u>	SW Z L F	46	rs.	violitio Dayo	Hodro	J. J	ul 23	, 1963		Maryland
_	Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town					-			
cto	Toa. State	Tob. County		Tuc. City, Town	or Loca	tion						10d. Inside City Limits
<u>ir</u>	MD	Balti	more	Ess	ex							1 🗌 Yes 2 🗷 No
<u></u>	10e. Street and Nun	nber				10f. Zip Code			10	g. Citizen of V	√hat Cc	ountry?
Funeral Director	820 Br	unswick R	oad Apt.	2A		2122	21			Unit	ed	States
ᆵ	11. Marital Status		12. Was Decedent I Armed Forces?		13. Wa	s Decedent of H es, specify Cuba	spanic Origin	1? (Specify Ye	es or No-			rican Indian,
ģ		ied 2 🗆 Married	1 Yes 2 H			Yes 22 No		-ueito nican,	etc.)		k, White	e, etc.
ted	3 🗌 Widowed		Year or Dates.		'-	⊥ies ∠⊯agino	эресну.			Specify:		White
ble	(Spe	15. Decedent's Edu cify only highest grad				nt's Usual Occup ed of work done o		f working	10	6b. Kind of Bu	siness	Industry
Completed by	Elementary/Seco	onday (0-12)	College (1-4 or 5		ife. DO I	NOT use retired)						
BeC	12				Ass	<u>embler</u>						Motors
0	17. Father's Name (/	First, Middle, Last)					18. Mother's	s Name (First	, Middle, Ma	iden Surname,)	
	Unk	Unk						Unk				
N	19a. Informant's Na	me/Relationship (Typ	oe, Print)	19b.	Mailing .	Address (Street a	and Number o	or Rural Rout	e Number, C	ity or Town, Si	tate, Zip	o Code)
	Angela	Smith /S	tep Daught	er	820	Brunsw	ick Ro	ad Apt	t. 2A	Essex,	MD	21221
= (1)	20a. Method of Disp	oosition Cremation 3 F	Damas val franc Chat-	20b. Place of	Disposit	ion (Name of tory or other plac	e)	Date		Dc. Location -	City or	Town, State
		5 Other (Specify)				e Cremat	i	20:	1 20, 10	Belts	svil	le, Maryland
	21. Signature of Fur	neral Service License	e s M	01443		Name and Addres	s of Facility					
	- Ju	Da Que	Ritton	0.00		Crematic						zland 21286
	23a. Part 1. En er ti	he disease, or compli rt failure. List only one	ications that caused	the death. Do no	t enter t							Approximate
	Immediate Cause (I	Final			AI	o o unti	-					Interval Between Onset and Death
	disease or condition resulting in death)	n e	a. Due to (or as	HOUIC a consequence of	011	-1-HUS	>				\rightarrow	2006
			240 10 (01 40	a consoquence of	,.						- 3	
ě	Sequentially list cou if any, leading to im		Due to (or as	a consequence of):						-	
Examine	cause. Enter Under Cause (Disease or i	rlying linjury			,							
EX	that initiated events resulting in death) L		Due to (or as	a consequence of):		_				\dashv	
ē												
Medical			J									
~ I	IF FEMALE: 23b. Was decedent	progrant 23	3c. If yes, outcome	of pregnancy						00 D		
siciar	in the past 12 r	nonths?	1 Live Birth	2 Fetal death		Ectopic pregnanc Other (specify)	у			23d. Date Mor		Day Year
<u> </u>	1 Yes 2 Unknown	J No	9 Unknown	it time of death	3 🗆 C	other (apechy)						
2	Part II. Other signifi	icant conditions con	tributing to death b	ut not resulting in	the und	erlying cause giv	en in Part I.	2	3e Did tobar	cco use contri	bute to	the cause of death?
6	HEPATTI			_				- 1				robably 4 🗆 Unknown
Completed b	HEPATI	- 0		-				- 1				•
힐	MEPATI	TISL						2	4a. Was an autopsy	р	rior to c	topsy findings available completion of cause of
3								1	performe		eath?	3 2 □ No
e De	25. Was case referre examiner?	_					ice of Death ((Check only c	one)			
2 │		3 NO	ospital: 1 🔲 Inpatio	ent 2 ER/Out	patient	3 □ DOA Othe	r: 4 🗌 Nursi	ing Home 5	Residence	ce 6 Other	r (Spec	ity) HOSPICE
ĕ	 Manner of Death Natural 	5 Pending	28a. Date of inju (Month, Day	ry 28b. Tii <i>(, Year)</i> inj	ne of ury	28c. Injury work		28d. D	escribe how	injury occurre	d	"
ceruncate	2 Accident	Investigation 6 Could not be					Yes 2 No	0				
	4 Homicide	determined	28e. Place of Injubul	ry - At home, farr	n, street	, factory, office			ocation (Streetly or Town, S		r or Rur	ral Route Number,
								0,	ty or rown, c			16
	29a. Certifier 1	Certifying Physic	cian: To the best of	my knowledge, de	eath occ	cured at the time,	date and pla	ce, and due	to the cause((s) and manne	r as sta	ated.
Med		Certifying Nurse	Practioner: To the	best of my knowle	dge, dea	th occurred at the	time, date an	ned at the tind ad place, and	due to the ca	use(s) and due use(s) and mar	io ine c iner as	cause(s) and manner stated. stated.
	29b. Signature and t	title of certifier				29c. License	number		29d	l. Date signed	(Month	ı, Day, Year)
	4	Pl	101	1/-		1 ,7)/	0439	15	1	Tucy	19,	2010
ŀ	30. Name and addre	ess of person who con	mpleted cause of de	eath (Item 23a) (Ty	pe, Prin			_				
	OPNIEW	OUBERN	CAN, MO	0701 R	Ch	AREKS S	TI 80	UTE 41	05 E	BALTIMU	PE.	MD 21204
	31. Date filed (Month	Tay Yes II on	32. Registra	ar's Signature	,							
7		20 20	10 Seren	un B.	100	What						
					- 8							

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 900 010 Medical County of Death (if not institution, give street and number) **Examiner** Itimore stow OSDI ave 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours N. Carolina 0974671344 65 Director 212-42-3486 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-1 sho amy injury or or or anaked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at Director tx☐ Yes 2 ☐ No Baltimore MD N/A10f. Zip Code 10a, Citizen of What Country? 10e. Street and Number Funeral 21207 U.S.A. 6609 Windsor Mill MD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. ģ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes Give 3
Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
Ferguson Trenching 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Co., INC. Mason 11th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Williams Joe Shackleford Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Shackleford(wife) 6609 Windsor Mill MD, Balto., MD 21207 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Joseph Brown 1 Burial 2X Cremation 3 Removal from State 07/19/10 Baltimore, MD 4 Donation 5 Other (Specify) nd crematory 22 Joseph H. Brown Jr. FUneral Home PA Signature of Funeral Service Licer 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to minimum at cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami that the death certificate be executed equence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ completed filled in by the funeral director, page 2 should be To the Hospital or Attending Physician: The law requires twithin 24 hours after death.
To the Funeral Director: After this certificate has been sign 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined 1 🏅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nly on

State Registrar 29b. S

gnature

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

5401

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 22461 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician TREQUELINE SMITH Day Year SPIES P M 9:10 2010 JULY 16 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howar olumbia Howard County General HOSPITAL 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number If Unde 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 DM 202 F Months Director Dec 10, 036-24-4239 1937 Rhode Island Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Directo MXYes 2 □ No Florida Martin Stuart 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2929 E. Ocean Blvd. Funeral 34996 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2**XX**No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 10 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any Injury or other traumatic event, Itel Posicial Eventuring once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □ Yes 2 □XN Specify. Specify: White ģ 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) years Broker Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin H. Smith ည Madonna Noon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kurt Spies son 12107 Apache Tears Circle Laurel, Maryland 20708 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State W. Arundel Crem. 4 ☐ Donation 5 ☐ Other (Specify) July 20, 2101 Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Avenue M00770 Laurel, Maryland 20707 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancer -Una C months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ned by the a detached f 9 Unknown signed I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ icate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? **Division of Vital** 2 No 1 ☐ Yes 2 🔭 No 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

8600 Snowden River PKWy #301, Columbia,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		State of Maryland / Dep		•					
		. 101	rtificate of Death	Reg. No.	/ 11 1 11 11 11 11 11 11 11 11 11 11 11				
Physi	cian	1. Decedent's Name (First, Middle, Last)	provick	2. Date of Death Month Day 12	3. Time of Death				
/Med	dical	40 Facility Ni and in the distriction of the distri	4b. City, Town, or Location of Death		ZCIC 22:12 M				
Exam	iiner	The Johns Hopkins Hospital	Baltimore City		×				
Funera		5. Social Security Number 141-48-0363 6. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Sept 6, 195	Birthplace (State or Foreign Country)				
Directo	r	Usual Residence of Decedent		Sept 0, 193	2 Pennsylvania				
anylane show	_	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 ☒No				
the Mi 28a-f otified	Director	10e. Street and Number	10f. Zip-Code	10g Citize	en of What Country?				
h with 23a or st be r			21220	USA					
r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14 Rican, etc.)	4. Race - American Indian, Black, White, etc.				
336 Irs afte	by F		1 ☐ Yes 2 🔀 No Specify:		Specify: White				
21215-0036 ed within 72 hours aft giene. er than "natural", or the Medical Examir	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ina 16b. Kin	d of Business/Industry				
121 within and the Med	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Ite.	DO NOT use retired) ntal technician		ealthcare				
id 2	Be Co			e (First, Middle, Maiden S					
ylan vuld be Mental arked	일	Joseph Surovick	Franci	ls Pitzo					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	î		ng Address (Street and Number or Ru. Budd Blvd; Woodb :						
Baltimore, M permit. Pages 1 and 2 Department of Heath 8 Important: If item 27 i any injury or other tra		20a. Method of Disposition 20b. Place of Disposition	osition (Name of matory or other place)	Date 20c. Loc	ation - City or Town, State				
Page ment c ant: If ury or		4 Ropation 5 Other (Specify) in State	matory or outer place)						
Balt permit. Depart Import any inj		21. Sig ature (Funeral Service Liversee Ronal Warie, Frector	2. Name and Address of Facility State Anatomy Box		Baltimore Street				
		23a. Part 1. Enter the disease, or complections that caused the death. Do not en	Baltimore, Maryl: ter the mode of dying, such as cardiac		Approximate Interval Between				
Physician		shock or heart failuré. List only one cause on each line. Immediate Comie (Final disease or condition MUC Cardia) 150	hemia		Onset and Death				
/ /Medical Examiner	_	resulting in death) Diff to (or as a consequence of):	5.6						
		Sagus flating liet conditions, if any, leading to immediate cause. Enter Underlying	omyopathy						
cuted Id ransit	Examiner	Cause (Disease or injury that initiated events c. Coronary arter	y disease						
60, be executed sician and burial-transit	ical E)								
BOX 68760, eath certificate be executed attending physician and for use as the burial-transit	8								
BOX (leath certi attending	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy	23	23d. Date of delivery				
- 0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 1 □ Yes 5 □ Unknown	Other (specify)		Month Day Year				
dets	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?				
Hecords, ne law requires t has been signe				1 les 2	No 3 ☐ Probably 4 ☐ Unknown				
HeCOr le law requ has been ge 2 shou	Completed			24a. Was an autopsy performed?	prior to completion of cause of				
			26. Place of Death	1 Yes 2 No	1 ☐ Yes 2 ☑ No				
⊢ % σ	To Be	examiner?	Other:	me 5 Residence 6	☐ Other (Specify)				
on o ding Ph h. After thi funeral			Work?	28d. Describe how injury	occurred				
or Attending after death. Director: After lin by the fune	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined building etc. (Specify)			Number or Rural Route Number,				
pital or / burs after eral Dire	Certification:	building, etc. (opocity)							
UNISION Hospital or Attend 24 hours after death Funeral Director: Fetely filled in by the	edical	29a. Certifier 1							
To the Hosp within 24 ho To the Fune completely f	Med	29b. Signature/and title of certifier	29c. License number	29d. Date	signed (Month, Day, Year)				
		1 Jahl le	RES 000	Jul	y 12 2010				
		30. Name and address of person who completed cause of death (Item 23a) (Type,		North Wolfe St.	, Baltimore, MD, 21287				
_	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature							
Regis	ırar	JUL & V ZUIU Klower B. 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 22453 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas Schoenborn 2010 12:02PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1208 Grafton Shop Road Harford Bel Air If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Days Hours 1 🛛 M 2 🗆 F New Jersey Director 89 <u> 156-07-7603</u> Nov. Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1208 Grafton Shop Road 21014 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or þ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Soup Manufacturing 8 Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otto (nmn) Schoenborn Julia (nmn) Mullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Schoenborn / Son 1208 Grafton Shop Road, Bel Air, Maryland, 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite 1 Burial 2 X Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Hilltop Service Corp. 7/19/2010 Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. Kathleen netwasce 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ MYONIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Plemal effusion Completed 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? page 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 7/16/16 028489 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fleta 1 Sokcal MD 615 W Nac Phael Pol Ste 105 Bol Air Wd 21014 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Ιį	For State Registrar		State of	of Maryla		artment of I tificate of L		and M	ental Hy	giene Reg. No	00	10	22464
1. Decedent's Name (First, Middle, Last) 2. Date of Death								Vaar	3. Time of Death					
Medi	cal	Bertie Rue Short July 13, 20								Year 010	9:00AM M			
Examir	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of												
Funeral		17 Fox Run Court S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. [If Under 24 Hrs. 8. [If Under 25 Hrs. 8] Hrs. 8. [If Under 25 Hrs. 8] Hrs. 8 [If Under 25 Hrs.						8. Date of Bir	Baltimore e of Birth 9. Birthplace (State or Foreig					
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aor2 beno	<u> </u>	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?				
th with ms 23 must	ner	17 Fox Run Court 11. Marital Status 12. Was Decedent Ever in U.			S. 13. Was Decedent of Hispanic Origin? (Specify Yes of					USA				
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IMOF Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 🛣 4 ☐ Donation 5			Otate		atory or other place remation	i	7/1/	/2010	ц	ampst	· o a d	MD
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DIVISION tal or Attendir s after death. al Director: After de ful		4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							8f. Location (Street and Number or Rural Route Number, City or Town, State)					
DIVISION OF VITAL RECORDS, P.O. BOX 68, To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
the H thin 24 the Fu	Me	only one) 3	Certifying Nur				eath occurred at the	e time, date		and due to th	e cause(s	and man	ner as st	tated.
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2		30. Name and address	of person who	completed caus		n 23a) (Type, Pr	int)							
ANAND DUTTA MID. 2401 W. BEWEDELLE AVE. BALTO. MP									4P 21215					
Stat Registra		31. Date filed (Month, I	Day, Year)	32. R	egistrar's Sign	acks								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 1 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month JACK SHARE /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 CANDLEMAKER COURT, #206 BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 07/18/1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months Days Hours Min. 85 PA 174-18-0405 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Mudical Evaniner must be notified at Director 1 □Yes 2 □ No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 4 CANDLEMAKER COURT, #206 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0, Baltimore, Maryland 21215-0036 1 □Yes 2**X**□No Specify <u>8</u> Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE CLOTHING is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental S₀L SHARE FRIEDA ၉ KLEVAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trat once. BEVERLY SHARE/WIFE 4 CANDLEMAKER COURT, #206, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PK 4 Donation 5 Dother (Specify) 07/18/2010 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and O Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical sequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Fureral Director: After this certificate has been signed by the attending physician and arely filled in by the furneral director, page 2 should be deteched for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 9 Unknown cate has been signed page 2 should be det sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 Unknown 1 □ Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 □Yes 24 25. Was case referred to medical examiner? Be 26. Place of Death (Che only one) Hospital: Other: 4 Nursing Home ၉ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ome 5 Residence 6 □Other (Specify)
28d. Describe how injury occurred 27. Manner of De 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 🗓 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year)

State Registrar ed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 22466 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day July 13, 2010 **Medical Examiner** 0915 hrs Wallace Simon 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours June 16,195 Foreign MD Director 219 66 5555 53 1 M 2 F Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD n/a Baltimore 28a-f show s 23a or 28a-f shove notified at once. 1 X Yes 2 No hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 835 N. Patterson Pk. 21205 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 Never Married 2 Married 1 Yes 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: Specify:Black 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. marked other than Baltimore, MD 21215-0036 11th Handyman Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Wallace Ella Player ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Deborah Simon (sister) 5421 Todd Avenue Baltimore, Md. 21206 20a. Method of Disposition Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from Stat permit. Page.
Department o
Important: 1 Mt.Zion Cem. July 22,2010 Balto,MD Onation 5 Other Specify ature of Funeral Service Licenses Carvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md on ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21213 Approximate Interval **Physician** failure. List only one cause on each line Between Onset and (Modical Death Immediate Cause (Final disease Examiner Reroin intoxication or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical #23a,27-28a-f,perME,G906,8/4/10,WS X UNPENDED attending physician or use as the burial -Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 ✔ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of this certificate has death? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other Nursing Home 5 Residence 6 Other 1 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: Afte Certification Natural Fd. 8:30 AM 5 Pending 1 Yes 2 X No Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc 2 Accident ınknown Investigation 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be or Town, State)3012 Rosaline Ave. determined Homicide House Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 14, 2010 30. Name/and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 22467 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 12:01 PM Jerome Charles Schweiger Medical 20104a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2309 Titan Terrace Havre de Grace Harford Social Security Number 90 (In yr. If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🛛 M 2 🗆 F Months Hours Min Country)
Maryland 11/18/1919 Director 216-03-4878 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a arrow once. 10c. City, Town or Location 10d. Inside City Limits Directo Maryland 1 Yes 2 No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2309 Titan Terrace 21078 USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 194 Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify: If Yes, Give 1943–1945 Year or Dates 1943–1945 Specify White Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Beverage 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Schweiger Marie Wuestner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Zwiebelman / Grandson 2309 Titan Terrace, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State acred Heart of Jesus 7/21/2010 4 \square Donation 5 \square Other (Specify) Tarring-Cargo Funeral Home, P.A 333 S. Parke St. Aberdeen, MD 2 21. Signatus of Ja 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death FAILURE Physician RESPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year 4 ☐ Pregnant at time of death g ☐ Unknown After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 Yes 2 No "Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifice completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 💢 No ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: injury 1X Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifie X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) July 19, 2010

State Registrar Registrace Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month U SE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NO 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 8. Firthplace (State or Foreign Months Days Hours Min Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10d. Inside City Limits 1 ☐-Yes 2 ☐ No 10e, Stree Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 1. Marital Status 14. Race - American, Indian, Armed Forces þ 1 Never Married 2 Married 2. No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during life. DO NO nuce retired) kind of work done during most of working Elementary Seconday (0-12) Be 17. Father's Name (First, Middle, Last) Name (First, Middle မ 20a. Method of Disposition Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signa ture of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 5 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be eximin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death Month Year 2 No as been signed by the 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy completed filled in by the funeral director, page performed?
1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 Tes 2 🗆 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Medical Examiner: On the basis or examination and/or investigation, in the opinion, usair occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 003035

12

State Registrar 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

			For State Registrar	State of Ma	-		rtment of F tificate of D		Mental Hy	giene Reg. No.	2010	22469
		,	1. Decedent's Name (First, Middle, L	ast)					2. Date of De	eath		3. Time of Death
F	hysicia Medio		Harry Lewis Tol	lley, Jr.					July	Day 18	y 2010	7:50 a.M
	Examir		4a. Facility Name (if not institution, g	ive street and number)			4b. City, Town, or	Location of Deat	h	4c.	County of Death	1
			127 Bayside Dr:	ive			Dunda1k			Ва	altimore	<u>. </u>
	uneral		Social Security Number 6	. Sex	(In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			9. Birth	nplace (State or Foreign intry)
	irector		216-20-2855 Usual Residence of Decedent	8	55 Y	rs.			Feb. 12	, 192	25 Vir	gínia
pu	how	ᅵᅟᇵᅵ	10a. State 10b. County		10c. City, Town	or Loc	ation					10d. Inside City Limits
aryla	la-f s	ect	Maryland Baltin	nore	Dunda1	k						1 ☐ Yes 2 🗓 No
he M	or 28 e not	[吉	10e. Street and Number				10f. Zip Code			10a Citi	izen of What Cou	
vith t	23a ist be	Funeral Director	127 Bayside Driv	7.0			21222				ed Stat	
eath	r mu	Ľ.	127 DaySIde DIIV	12. Was Decedent Ev	er in U.S.	13. V	as Decedent of Hi	spanic Origin? (S	pecify Yes or No-		14. Race - Ameri	
er d	or it	by I	1 Never Married 2 Marrie		No	l .	Yes, specify Cubar		o Rican, etc.)		Black, White	
) Irs af	ural"	eq	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	II WW	1	☐ Yes 2 💢 No	Specify:			Specify: Wh	ite
5-("nat	Completed	15. Decedent's (Specify only highest				ent's Usual Occupa		kina	16b. Ki	nd of Business Ir	ndustry
7 if a	than be Me	E O	Elementary/Seconday (0-12)	College (1-4 or 5-	+)	life. DC	NOT use retired)		9	р.		
d wit	nt, th	Be C	12 years	4)	Su	per	visor				rewery	
anc be file	ed o	70 E	17. Father's Name (First, Middle, Las					18. Mother's Na			Surname)	
James Me	mark		Harry L. Tolley						R. Bry			
Sahe 2 she than	27 is trau		Lois L. Tolley	(Wife)			g Address (Street a Bayside D				yland 21	
and and	tem		20a. Method of Disposition	(11220)			sition (Name of	1	Date		cation - City or 1	
nol age 1	rt: If i		1 Burial 2 Cremation 3	Removal from State	cemetery	ı, crem	atory or other place				son, Mar	
Baltimore, Maryland 21215-0036 oermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mernal Hydiene.	Important. If them Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sing ture of Tune 1 Service Line		1 HATILLO	_	Vervice C					
Be G	ang ang ang		Mal	11/-X	2011	Di 179	Name and Addres Ida-Ruck 122 Wise	Funeral Avenue	Home of Dunda1k	Duno Mar	dalk, Ir ryland 2	nc. 21222
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line.	the death. Do no	t ente	the mode of dying	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	sician/		Immediate Cause (Final disease or condition	Lux	JG C	pn	LEV				10	Onset and Death
	ledical aminer		resulting in death)	Due to (or as a	consequence of	n):						12-100
LAC		<u>,</u>	Sequentially list conditions,	b. —								
W.	oit .	Examiner	if any, leading to immediate	Due to (or as a	consequence of	r):						
ecute	and -trans	xar	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a	consequence of	n-						
Box 68760 death certificate be executed	physician and the burial-transit	g	Todaking in dodkiny Edot		00/1000440/10000/	/-						
760	phys s the	edical		d				-				
	nding Ise as	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy						23d. Date of deliv	von.
Box death c	atter I for u	iciai	in the past 12 months?	1 Live Birth 2 4 Pregnant at	Fetal death		Ectopic pregnancy Other (specify)	/] '	Month	Day Year
the de	has been signed by the attending le 2 should be detached for use as	Physician/M	9 Unknown	9 🗌 Unknown								
cords, P.O. law requires that the	ned b deta	by P	Part II. Other significant conditions	contributing to death bu	t not resulting in	the un	derlying cause give	en in Part I.	23e. Did t	obacco us	se contribute to t	the cause of death?
15,	in sig uld bu	ed		-					1 🗆	Yes 2	□ No 3 □ Pro	obably 4 Unknown
Vital Records, ysician: The law requires	s bee	Completed							24a. Was		24b. Were auto	ppsy findings available
he la	te ha	mo.							auto perfo 1 🗆 Yes	ormed?	death?	ompletion of cause of
an: T	rtifica tor, p		25. Was case referred to medical	1	и		26. Pla	ce of Death (Che		2 🗀 NO	_ I L ies	2 121 140
VIÇ	is cel direc	10 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1npatier	nt 2 🗆 ER/Out	patient	3 DQA Othe	r: 4 Nursing F	lome 5 🗹 Resi	dence 6	Other (Specif	(v)
ار ق	ter th	ië.	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,		me of jury	28c. Injury work?	at	28d. Describe I			
on endir eath.	or: Af	lica	2 Accident Investigat	ion	,	,		Yes 2 ☐ No				
Division of tal or Attending Phrs after death.	irect n by t	Certificate:	3 Suicide 6 Could not 4 Homicide determine		y - At home, farr (Specify)	n, stree	et, factory, office		28f. Location (S		Number or Rura	al Route Number,
Distal of urs at	iled ii											
Division of Vital Rec To the Hospital or Attending Physician: The Is within 24 hours after death.	Fune	Medical	(Check 2 Medical Exa	nysician: To the best of m miner: On the basis of exa	amination and/or	investig	gation, in my opinior	n, death occurred	at the time, date a	and place,	and due to the ca	ause(s) and manner stated.
o the	o the опріє		only one) 3 L Certifying No. 29b. Signature and title of certifier	urse Practioner: To the b	est of my knowle	dge, de	eath occurred at the 29c. License		ace, and due to th		and manner as s e signed (Month,	
F 3	Ρō		D (1/0,1)	Madia	nmn		Do	739110		Zou. Dale	7/19/1	()
		-	30. Name and address of person who	completed cause of do	atk (Itam 23a) (Ti	me D-	int)	00 1101	0	<u> </u>	111/1	U
4+	1		ALVIN S. MADAR	ANG, MD	808 L	AN	DMARK	DR. ST	£ 128 E	sleu.	Burnie	MDQ1061
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	20						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name First, Middle, Last) 2. Date of Dea Physician/ IRNOR nonu Medical 4a. Facility Name (if not institution, give street and number) County of Death N/AExaminer 4b. City, Town, or Location of Death 4105 Penhurst Avenue Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day **1**X□ M 2 □ F Months Days Hours Min. 49 Director 217-78-6534 Maryland 961 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location Director 10d. Inside City Limits 1 ¥ Yes 2 ☐ No Baltimore Maryland N/A10e. Street and Number 10f. Zip Code 21215 10g. Citizen of What Country? Funeral 4105 Penhurst Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Yes 2 🔀 No Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) Private Industry Carpenter <u>11th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ Jacqueline Gibson Melvin Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 4105 Penhurst Avenue Baltimore, Mary Land Jacqueline Johnson/Mother 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Woodlawn Cemetery 1 Burial 2 Cremation 3 Removal from State 7/17/10 Woodlawn, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility Chatman-Harris FuneralHome Reisterstown Rd Baltimore, MD 21215 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Approximate mmediate Caus (Final Onset and Death Physician/ 05 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [조 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy perform Yes 25. Was case referred to medical l a 26. Place of Death (Check only one examiner? ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) ledical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Date signed (Month. 30. Name and address of person who complet

State Registrar ed (Month, Day, Year)

31. Date file

DHMH 17 Rev 7/2009

32. Registrar's Signature

			Amend Items 9,11, 20a,b,c, 1-State Amend Item 2	Type or Print in 12,15,16a,b State of Mary pr me,g90	n Black Ir and / Pepa Cer	delible In 9a, b, 20a 2010 th By tificate of I	k, Ensure b,c per lealth and 22perFH,G Death	All Copie Th, g905 Mental Hy 905,77207	s Are J giene 2 Reg. No.	c eible O 1 0	dhb22471
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
~ ~	Medi Examir		Donald Travers 4a. Facility Name (if not institution, give si	treet and number)		4b. City. Town, o	r Location of Deat	1701X	3 0 4c C	Dunty of Deat	1052/ M
			Good Samar	itan Hosp	Ita/	BaHi	more	1	10.0	ounty of Boat	
	Funeral Director		213-34-09/9	7. Age (<i>ln yr</i> 71)	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th ¹ /1 ⁹ 39	9. Birt Coa	hplace (State or Foreign Intr yunk MD
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County MD	10c.	City, Town or Loc						10d. Inside City Limits
	ne Mai or 28a notifi	Director	10e, Street and Number		Daitimo	10f. Zip Code	-		10g Citizo	n of What Co	1 🖰 Yes 2 🗆 No
	with the s 23a of ust be	Funeral	1438 Winston Ave	nue		21212			USA		unuyr
336	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Heath and Mental Hygiene. Infinordant: I fire X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Š	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🙀 No		pecify Yes or No- to Rican, etc.)	14	. Race - Amer Black, White ec <i>ify:</i> bla	e, etc.
2	hours 'natur dical l	olete	15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	lent's Usual Occup	pation	ad star as	16b. Kind	of Business I	ndustry 4
2121	within 72 /giene. ner than ' t, the Me	e Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	Recondi	•	rking	Balt		Vashington
yland	d be filed Mental H arked otl atic even	To Be	17. Father's Name (First, Middle, Last) Robert J. Trave			1		me (First, Middle, er Water		rname j UTI k	
Baltimore, Maryland 21215-0036	and 2 should be file f Health and Mental H tem 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type Good Samaritan II Donald Travers Jr	osnitel-	19b. Mailin	g Address (Street) 1 Loch R Dalhousi	and Number or Ru aven Blv e Court,	ral Route Number Baltimo	er, City or To	wn, State, Zip Mary 1 D	Code) and 21239
imore	Fage 1 a ment of H ant: If ite ury or ott		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 ☒ Other (Specify)	emoval from State	ownsvil.	le Cemeto	ery 07/	Date /13/2010	Crov	tion - City or ` msvil	le, MD
Balt	Depart Depart Import any inj	. 1	21. Signature of F et al Service Licensee n1e/ A	Naylor	22	Name and Addre	ss of Facility Jos 10 tomy Fulton	eph H 55 ve 38a	Brown 1timo	Funera re, MD	1 Home PA 21217
	hysician/ Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	hmia equence of):	r the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
Pot.	ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a conse	ation equence of):		ERTIFICATION APPR	WED BY MEDICAL	EXAMINER	6-1	
60 ste be evenited			that initiated events resulting in death) Last	Due to (or as a conse	equence of):	ď	ERTIFICATION APPR	On	2		
. Box 68760	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3 🗀	Ectopic pregnand Other (specify)	sy		230	d. Date of deli Month	very Day Year
s, P.O.	signed by	ρ	Part II. Other significant conditions cont DiLated Cardi	-	•	nderlying cause giv	ven in Part I.	1			the cause of death?
Division of Vital Records, la or Attending Physician. The law requires	certificate has been irector, page 2 shoul	Completed		7-1-	B			24a. Was autor perfo	osy ormed?	prior to c death?	opsy findings available ompletion of cause of
	ertifica ctor, p	BeC	25. Was case referred to medical			26. Pf	ace of Death (Che		2 No	1 L Yes	2 121No
r VII	this ce al dire	욘	examiner? 1 Yes 2 Ho 27. Manner of Death	spital:			4 L Nursing F	iome 5 ☐ Resid	dence 6 🗆	Other (Speci	fy)
ION O	leath. :or: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work M 1 🗆		28d. Describe h	now injury oc	curred	
DIVIS	ırs after c ral Direct lled in by		4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	sify)			City or Tow	ın, State)		al Route Number,
the Hosp	rin 24 hou the Fune npleted fi	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	an: To the best of my kno r: On the basis of examinat Practioner: To the best of	ion and/or investi	gation, in my opinic	n, death occurred:	at the time, date a	ind place, an	d due to the c	ause(s) and manner stated.
ToT	To t con	- 1	29b. Signature and title of certifier **Vethlem TSI**	hellumo		29c. License	o 62689		_	igned (Month,	
			Nathleen ISO 30. Name and address of person who con Kathleen L. Sh	appendicause of death (Ite	em 23a) (Type, Pr	int)		-		} - / -	
	Stat Registra	e r	31. Date filed (Month, Day, Year) JUL 15 2010	32. Registrar's Signature	nature						

			State of Maryland / Depa		ental Hyg	giene		0.01
			Registrar 1. Decedent's Name (First, Middle, Last)	ificate of Death		Reg. No. 2	10	22472
	Physicia		CHARLES NEIL KIRKBRIDE TAYLOR		2. Date of Dea Month	Day	Year	3. Time of Death
	Medic Examin			4b. City, Town, or Location of Death	JULY	18 20 4c. County o	010	10:00 A M
	, LAGITIM		711 Park Avenue, #9	Laurel		Prince		orge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	1	9. Birthpl	ace (State or Foreign
	Director		164-26-9813 Ax. 79 Yrs.	Willins Days Hours Willi.	(Month, Day Aug 4,	1930	Countr	W.Va.
	nd how at	<u>ا</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			10	d. Inside City Limits
	faryla 3a-f s tified	Director	MD Prince George's Laurel					1 kg√xes 2 □ No
	the M	اقّا	10e. Street and Number	10f. Zip Code		10g. Citizen of Wh	nat Count	2121
	s 23a nust b	Funeral	711 Park Avenue, #9	20707		U.S.A.		
	death item ner n		Armed Forces?	as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F	ify Yes or No-	14. Race		
36	after Il", or Xamii	d by	1 Never Married 2 A Married 1 Yes 2 X No	Yes 2 XX No Specify:	,	0 "	White, et	
ş	atura	Completed by	rear or Dates.	nt's Usual Occupation		16b. Kind of Bus	Whit	
215	n 72	mp	(Specify only highest grade completed) (Give kill	nd of work done during most of workin NOT use retired)	g	Banking	iriess iriai	astry
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nd	e filed Ital Hy ed ott	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		Maiden Surname)		
<u>\Z</u>	uld be d Men narke natic	_	Roland Taylor	Reta Woo				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	g is		Address (Street and Number or Rural 56 Kings Post Ct.				ode) 20723
ē	f Heal f Heal item		20a. Method of Disposition 20b. Place of Disposi	tion (Name of D	ate	20c. Location - C		
E E	Page nent o nt: If ry or		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State cemetery, cremation 4 ☐ Donation 5 ☐ Other (Specify) West Arun	tory or other place)		Odenton,	-	
altı	rmit. F partin porta y inju	l		Name and Address of Facility Don.				
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or	respiratory arre	est,		Approximate Interval Between
y	Pnysician/		Immediate Cause (Final disease or condition Coronary Artery D	isease			1	Onset and Death 20 Years
	Medical Examiner		resulting in death) Due to (or as a consequence of):	1				
		er	Sequentially list conditions, If any leading to immediate Heart Block - Pace	emaker ————————————————————————————————————				
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Ÿ	n and al-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):					_
2	*Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	d					
00/00	tificat ng ph as th		IF FEMALE:	•				
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Ċ.	at th		Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tol	bacco use contrib	ute to the	cause of death?
'n	ires the signer of the signer	d by			1 □ Y	es 2 XX No 3	☐ Proba	ably 4 Unknown
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<u></u>	ian: T rtifica stor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check of		2 234 0 1 L	⊥ Yes 2	(LANO
N La	hysic nis ce I direc	2	1 Yes 2 XX III Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Hom	ne 5 🛚 🛣 Keside	ence 6 🗆 Other	(Specify)	
5	ling P	ate:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	3d. Describe ho	w injury occurred		
2	death death stor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	00 1 12 (0)		5 15	
Ž	after after Direction by		4 Homicide determined 286. Place of injury - At nome, farm, stree building, etc. (Specify)	t, lactory, office	City or Towr	reet and Number (n, State)	or Hurai H	route Number,
1	pspita hours ineral d fille	Medical	29a. Certifier 1XXCertifying Physician: To the best of my knowledge, death oc	cured at the time, date and place, and	due to the cau	se(s) and manner	as stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Mec	(Check 2 ☐ Medical Examiner: On the basis of examination and/or investig only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, dea	ation, in my opinion, death occurred at t	ne time, date an	d place, and due to	o the caus	e(s) and manner stated.
	Voit To t		29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Da	ay, Year)
•			N. F.	1)1804		7/19	110)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Prir Michael Keleman, M.D. 5450 Knoll North		M=7		4 =	
	Stat	9	31. Date filed (Month, Day, Year) 32. Registrar's Signature	n Drive Columbia	, maryl	and 210	45	
	Registra	-	JUL 20 2010 Senera D. Jacks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18 per FH, G905, 7/2072010, WS
State of Maryland / Department of Health and Mental Hygiene 0 1 0 22473 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 12:10 NPM Robert William Walter July 19 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Lutherville Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Nov 19, M 2 □ F Months Days Hours Min. 90 Director 219-03-1879 1919 Maryland Usual Residence of Decedent or 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Lutherville Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Rd 21093 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Xyes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 🗌 Never Married 2 🗌 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 12:10 p.m. Specify: 3 ₩idowed 4 □ Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 Mechanic Automotive Be 18. Mother's Name (First, Middle, Maiden Surname)
Swift
Blanche
Burns 17. Father's Name (First, Middle, Last) William 19, 2010 Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Harris /Son 1315 Dorsey Ave. Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20 Jul 4 Donation 5 Other (Specify) Beltsville, Maryland 2010 Chesapeake Crematory 21. Signature of Funeral Service Licensee 401585 22. Name and Address of Facility Cremation and Funeral Alternatives he 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ DEMENTIA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or in that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Medical Certificate: To 1 🗌 Yes 2 🗶 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date/signed (Month, Day, Year) NE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONES, JACKIE **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

ROBERT WALTER

			1 - For State Registrar	State of Maryland		artment of H		, ,	iene eg. No.2 0	10	22474
Jeg.	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last, Eloise Walker					2. Date of Death Month July	10 20	Year 010	3. Time of Death 10:35 A ^M
,	Examir Funeral	м	4a. Facility Name (If not institution, give 3001 St. Clair Dr 5. Social Security Number 6. Se;	ive; Apt 313	st birthdav)	4b. City, Town, or Abingdo If Under 1 Year		8. Date of Birth	4c. County of	ord	e (State or Foreign
	Director		218-22-8346 Usual Residence of Decedent]M 2⊠F 88	Yrs.	Months Days	Hours Min.	Oct 19,	1921	South	Carolina
	with the Maryla a or 28a-f shor	Director	MD Harfor 10e. Street and Number	d Ab	ingdo			10	og. Citizen of W		Inside City Limits 1 □ Yes 2★ No ?
036	be filed within 72 hours after death with the Maryland tial Hyglene. do other than "natural", or items 23a or 28a-f show event, if a Madical Evention of the property of the Madical Evention of the property of the Madical Evention of the Madical	by Funeral	3001 St. Clair D 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes, 21 No If Yes, Give Year or Dates;	1	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race Black	- American , White, etc. black	
21215-0036	d within 72 hou giene. er than "nature" ur Medicel E	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12) 1 2	cation	(Give life. l	dent's Usual Occupa kind of work done of DO NOT use retired chine open	during most of wor)	king	16b. Kind of Bus		try
yland	be d	To Be C	17. Father's Name (First, Middle, Last) Willie Black				Bessie				
e, mar	D = C +		19a. Informant's Name/Relationship (Ty) Florence Taylor 20a. Method of Disposition	- friend	113	ng Address (Street and Patriots Sition (Name of	s Way; E.	lkton, Ma	-	21921	
Saltimor	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	8	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Conation 5 13 Other (Specify)	n state		sition (Name of natory or other place Name and Addres State And	-				
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	ate be executed mysician and he burial-transit a	dical Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):		,			54	* L +
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r , SDIO	equires that en signed t	by P	Part II. Other significant conditions con		-	nderlying cause give	en in Part I.		acco use contril s 2 🙀 No 3		cause of death? y 4 ☐ Unknown
יי היי	: The law ra cate has be page 2 sha	Completed	PULMONARY HY					24a. Was an autopsy perform	pr ed? de		findings available etion of cause of
) i	Physician this certifi al director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ E			r: 4 □ Nursing H	th (Check only one ome 5 The Reside	nce 6 Other		
I SIOIS I	o the Hospital of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	27. Manner of Death 1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 2 ☐ Could not be determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At hombullding, etc. (Specify)	8b. Time of Injury e, farm, stre		rat ? /es 2 □ No	28d. Describe how 28f. Location (Str City or Town,	eet and Number		oute Number,
	n 24 hours ne Funeral bletely filled	edical Ce	29a. Certifier (Check only one) Certifying Phys 2 Medical Examir	ician: To the best of my knowler: On the basis of examination and manner stated.	edge, death on and/or inv	occurred at the time	ne, date and place pinion, death occu	e, and due to the ca rred at the time, da	ause(s) and mar ite and place, ar	nner as state	ed. e cause(s)
	withir Comp	Me	29b. Signature and title of certifier	d in s	ng_) /75.		number		d. Date signed		r, Year)
	Sta	te	30. Name and address of person who con CHILL? HAUTEAD, A.(602 South at 0	usos &		BELAIR	ma yoly			

DHMH 17 Rev 1/2001

Bradley Allen V	Vilhe	elm Sta 1- For State Registrar	te of Maryland	/ Depa	rtment of	Health a	and Menta	al Hygi	iene		10	22475
Physic		 Decedent's Name (First, Middle, 	•						Date of Death	Day Yea		Time of Death
Medical Exam	ııne	Bradley A 4a. Facility Name (if not institution,				4. 6:		J	uly 18, 20	10		1609 hrs
		1689 Exeter Road				4b. City, Town, Westmins	ster			4c. County of		
Funera Director		216 12 2152	.Sex 7.Ag I	e (In yrs. Ia 27	ast birthday) Yrs	If Under 1 Y	ear If Under ays Hours		. Date of Birth	_(ММ/DD/YYYY) -1982	Foreign	ace (State or ry)MD
* any		Usual Residence of Decedent 10a. State 10b. County MD Carr	011	10c. City,	Town or Locati		A				10	d. Inside City Limits
Maryland 28a-f show any d at once.	Director	10e. Street and Number				10f. Zip Code		er —	10g	. Citizen of Wh		Yes 2 X No
th the N 23a or :	ig le					211				JSA		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Departmet of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Marr 3 Widowed 4 Divoro	12. Was Decedent Armed Forces? 1 Yes 2 2 2 3 3 4 4 5 7 7 7 8 7 8 7 8 8 8 8 8 8 8 8 8 8 8 8		If Yo	s Decedent of I	oan, Mexican, F			White		Indian, Black,
iours af Laturali Xamin	d b	15. Decedent's Education (Specify	or Dates:	pleted)	16a, Decedent	's Usual Occup	pation (Give kir		done 1	6b. Kind of Bus	siness/Indu	stry
036 ithin 72 h ne. r than "n Tedical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	-	ost of working li undscaj		se retired)		Lands	cape	
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212 ould be Menta marke	To Be	19a. Informant's Name/Relationship	_		19b. Mailing	Address (Str	_		etta I) y son er, City or Town	State 7ii	Code)
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spec	ify:	Eve						Finks		
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Records, P.O. Box 68760, The law requires that the death certificate b icate has been signed by the attending physin page 2 should be detached for use as the bun	/sician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant at t	-	2 Feta	al death 3 er (Specify)	Ectopic pr	regnancy	·	23d. Date of d Month	elivery Day	Year
i, P.O. Baires that the designed by the	by Phys	Part II. Other significant condition Fatty Liver		but not res	sulting in the un	derlying cause	given in Part I				_	cause of death?
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 X Could no determin			ne, farm, street,	factory, office	building, etc.		or Town, State)		oute Number, City
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To Cor	Me	29b. Signature and title of certifier	and manner stated.			29c. Licen	se number		29	d. Date signed	(Month, L	Day, Year)
1		Yamle Truthal	completed cause of de	ath (Item 2	3a)	0.0	M.E.	_	J	uly 19, 2010	o 	
\square		Pa mel a E. Southall, MD	Assistant Medic	,	,	Penn Stree	et, Baltimor	e, MD 2	1201			
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For Amend Items 25,26,27,244 and Department of Health and Hygiene 22476 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year MABIS RICHARD 12.507M 0.5 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Future Care - Charles Village Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours Min. Jan 10, 1940 Virginia Director 70 230-60-0103 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director must be notified 28a-f MD 1 Ex Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code አ 10g. Citizen of What Country? Completed by Funeral 23a 2315 Madison Street 21215 USA ral", or items 2 Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced nt of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupationunk (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industryunk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roosevelt Webb Irene Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Artie Shaw/guardian 10 North Calvert Street; Baltimore, Maryland 21202 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) In State cemetery, crematory or other place) Funeral Service Licensee ^{22.} Name and Address of Facility Board; 655 West Baltimore Street Actor Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ neta statu disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cordio m burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Openuc Dicea P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen Disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perforr death? 24 hours after death. E Funeral Director: After this certificate 2 🗌 No Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 🗶 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie ٥ 29d. Date signed (Month, Day, Year) MD D31464

Registrar

State

821 N. ENTAWST Sonte 30 & BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HASEMI MD

31. Date filed (Month, Day, Year)

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death tarkville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min Mary Land Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No Marvland Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 158 Jumpers Circle U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 XNo Specify: "natural", 3 XWidowed 4 ☐ Divorced Completed er than "natura, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. it. Page 1 and 2 should be filed withinthent of Health and Mental Hygiene rtant: If item 27 is marked other the njury or other traumatic event, the Baltimore County Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ No1te Grinath John H. Florence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Beverly deLeyer</u> Baltimore, Maryland 2506 Ebony Road 20a, Method of Disposition 20b. Place of Disposition (Name of Important: If it any injury or o 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 7-20-2010 Service Corp. Towson Maryland Hilltop 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Marvland 1050 York Road Towson, 23a. Part 1. Enter the disease, or complications that caused the neath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bhysician/ disease or condition Medical resulting in death) ue to (as a consequence Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably /4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?
Yes 2 No After this certificate 1 🗆 Yes 2 🗆 No 1 Yes ours after death. eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PV

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day) Year)

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month ANNA MAY WILLIAMS 7:15P 18 July 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place 830 West 40th Street None Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Dec 18, 1919 Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🙀 F Yrs Mary Land 90 212-20-5212 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1**XX**Yes 2 □ No Maryland None Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 830 West 40th Street 21211 USA 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ZXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2XX No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Educator Baltimore County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward Williams Marian Welch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POA 1122 Charmuth Road Timonium Marvland 21093 Mary Helen Cooper 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery July 22, 2010 Brooklyn Park Maryland □Donation 5 □ Other (Specify) Signature of Funeral Prvice Lice 22. Name and Address of Facility Mitchell-Wiedefdeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MELITUS 1aBETES disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed Yes 2 No Yes 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

physiciar

certificate

the Hospital or Attending Physician:

2

within 24 hours a To the Funeral I

Physician

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

'natural",

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

the Medical

hours after death

within 72 al Hygiene.

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

Be

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/Medical

the burialast nse for signed by the a 2 2 pag nours after death.

neral Director; After this certific
filled in by the funeral director,

Be Completed by Physician/Medical

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 Unknown

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 5 Pending investigation Injury 1 Natural

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

imorp

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier LUUWI

6 ☐ Could not be

102

29d._Date signed (Month, Day, Year) 19 ,2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Don m.D 5901 North 31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:000 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town_or Location of Death 4c. County of Death tomore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 Months Days Hours Min. Director Carlen Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland Director 1 ☑ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 NO Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name First, Middle, Maiden permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) Route Number, City or Town, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place) 1 Nurial 2 Cremation 3 Removal from State 3 4 Donation 15 Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. uch as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Atten schools ₽hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Other (specify) Month Pregnant at time of death Day Year signed by the a d be detached f 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, To the Hospital or Attending Physician: The raw requirement within 24 hours after death.

To the Funeral Director. After this certificate has been significated filled in by the funeral director, page 2 should the funeral director. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed 1 ☐ Yes 2 ☐ No Yes 2 Wo 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 5 Pending Accident 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) 0043375 2010 of person who completed cause of death (Item 23a) (Type, Print) SUITE 203 PSALTITION, MD ZIZO9 2835 SHITH

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Louis J. Amistadi :45P Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Summerville Assisted Living Westminster Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours (Month, Day, 160-20-8971 1**火** M 2 □ F 85 Director arch <u>Pennsylvania</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Carro11 Md Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 6500 Mirrored Scene Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? 1X Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 XMarried Maryland 21215-0036 White 1 Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) American Bridge 10th Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Angelina Saibanti Carlos J.Amistadi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Mirrored Scene Ct. Sykesville, Md. 21784 <u>Donna L. Hansen</u> Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Good Samaritan Cemetery 7-20-2010 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral HOme 9705 Belair Rd. Nottingham, Md, 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) mis Medical (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **Natural** injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accider ☐ Suicide Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20/0

State Registrar Westmister

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Allen Year Calvin **Physician** Tulu 10 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Assisted Living Howard Sunrise olumbia 7. Age (In yrs. last birthday) der 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** · 1922 237-22-3903 Months Days Hours Min. Raleigh, North 1 M M 2 □ F 87 Director Carolina Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar in ust by notified at Director 1 X Yes 2 ☐ No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 6500 Freetown Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🗓 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Ductwork Roofing Co. Roof Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Evans Fred Allen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1401 Kenhill Avenue Baltimore, Maryland 21213 19a. Informant's Name/Relationship (Type. Print) 1401 Kenhill Avenue Katie Taylor (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2010 Brentwood, Maryland Lincoln Cemetery Ft. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall March Funeral Homes re of Funeral Service Licens 4217 9th Street, N.W. Washington, D.C. 20011 Approximate
Interval Between
Onset and Death

Q YEARS 23a. PM 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** oronaru disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed liabete mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2**X** No 1 TYes □Yes 2x53N0 25. Was case referred to medical filled in by the funeral director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Wher (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ca 29a, Certifier 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li, 8600 Snowden River Pkwy #301, Columbia, MD 21045 Harry Li 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Year

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

			for State Registrar	State of Maryland / [Department of F			2010	22483
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) 4a. Fecility Name (If not institution, give s			or Location of Death	2. Date of Death Month	Day Year 201'	-
	Funeral Director	1)	5. Social Security Number 003-44-9141 Usuel Residence of Decedent	in alle	nthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug 7,	(ear) 9. Bin Co	hplace (State or Foreign buntry) Hampshire
	the Maryland 28a-f show	ector	10a. State 10b. County Maryland Anne Aru 10e. Street and Number	ndel	Glen Burnie	1	100	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
	hours after death with the Maryland tural', or Iteme 23a or 28a-f show al Examiner must be notified at	by Funeral Director	304 Whitman Court	12. Was Decedent Ever in U.S. Armed Forces?	210 13. Was Decedent of Mif Yes, specify Cub			USA 14. Race - Ame Black, Whit	encan Indian,
9500-612	d within 72 hours after death with the Marylan jene ir than "natural", or Iteme 23a or 28a-f show the Medical Examiner must be nutified at	Completed by F	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade	completed)	1 ☐ Yes 2 No Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work	ing 16	Specify: Wh	nite
and 212	be file ad othe event,	To Be Comp	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Arthur Beloin	College (1-4or 5+)	Laborer		e (First, Middle, Ma		oction
e, mary	s 1 and 2 should if Health and Men item 27 is marke other traumatic.	1	19a. Informant's Name/Relationship (Ty, Jean Luc Beloin, 20a. Method of Disposition	Brother 45	o. Mailing Address (Street 3 Route 253 of Disposition (Name of ry, crematory or other pla	and Number or Run East - H	ereford (City or Town, State, 2	3150
baltimor	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Metro	Crematory I	nc. 07/1 Society	Of Marvla	and. Inc.	Maryland
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VISION OF V	ng Phy Iter this Ineral d	은	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Time of 28c. Injury Wo	ry at	me 5 Residen 28d. Describe how	ce 6 Other (Spe	cify)
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	al Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	,	me, date and place	City or Town,		
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examir one) 29b. Signature and title of certifier	ner: On the basis of examination an and manner stated.	d/or investigation, in my o	opinion, death occur	ed at the time, date	e and place, and due	e to the cause(s)
/	OV		30. Name and address of person who co	mpleted cause of death (Item 23a)	(Type, Print) So	57 -A A	mapoli	5 Colors MD	191401 19161
	Sta Registr	- S	31. Date filed (Month, Day, Year)	32. Rygistrar's Signature	parter		,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N 2 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ July 2010 Betty Lou Beach 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Continuing Care Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days 1 □ M 2X F Hours May 1, 1932 Maryland Director 216-28-2706 78 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 801 Winters Lane #244 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marguerite E. Weber Theodore Charles Krause 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Rajcsok, Daughter 1468 Thies Drive Pasadena, Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 07/19/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complicate ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of Immediate Cause (Final et and Death an cer Physician/ disease or condition resulting in death) Medical Due to (or as a con equence of): Examiner 0 2000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine that initiated events resulting in death) Last Due_to (or as a consequence of): attending physician for use as the burial Physician/Medical 2010 Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 month Month 9 Unknown P.O. ed by t detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Assisted 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month. Dav. Year) 221 D dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and MAZUPO 105

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Burford 7:15 AM William A. TULY Medical 2010 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death G-000 SAMARITAN HOSPITIAL N/A Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Maryland Months Hours Nov. 23, 1914 **Director** 95 213-03-8851 Usual Residence of Decedent ishow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/A 1 X Yes 2 No Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21239 **Belvedere** Avenue 1651 East United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) General Merchandise Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Augustus Burford Grace Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc Burford, Son 5635 Morning Glory Trail, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State New Cathedral Cemetery July 21, 2010 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Paysician/ Medical Due to (or as a consequence of): **Examiner** NEUMINIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): OSTEOMYELI TIS RIGHT FOOT Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day ned by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fart I. 23e. Did tobacco use contribute to the cause of death? Be Completed by s been signe should be d 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate 1 🗌 Yes 2 🚡 completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ည 1 Yes 2 110 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending work' 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral C Medical 🖫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier fluired, my D0061789 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORPAINE OFOR-AWUAH, MD-5430 CAMPBELL BLVD, STE 214. BALTIMORE MD 21236

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

		4	For State	S	tate of	Maryla		artment of H		and M	ental Hy	/gien	е			
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		30	D. Name and address of person w	ho complet	ted cause o	f death (Iten	n 23a) (Type, Pr		v 0 77 1				1.0	110		
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DHMH 17 Rev 7/2009

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Division of Vital Records, P.O. Box 687 to the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as t	Completed by Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2	months?	23c. If yes, outcome of Live Birth 2 4 Pregnant at 9 Unknown	2 🔲 Fetal	death 3	Ectopic pred Other (spec	gnancy ify)				23d. Date of Month		/ ay Year -
at the d by the letache	Phy	g ☐ Unknowr Part II. Other signi		ontributing to death bu	ıt not resu	Iting in the u	nderlying cau	ıse given in Pa	rt I.	23e. Did t	obacco	use contribute	e to the	cause of death?
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iviSi lor Att after d Direct	Certificate:	4 Homicide			ry - At hon . (Specify)	ne, farm, str	et, factory, o	ffice	28	8f. Location (City or To		nd Number or te)	Rurai H	oute <i>Number</i> ,
Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s	Medical		Modical Evam	rsician: To the best of r iner: On the basis of ex se Practioner: To the b	amination	and/or inves	igation in my	oninion death	occurred at the	he time, date	and place	ce, and due to t	he caus	e(s) and manner stated
To the within To the compl	Σ	29b. Signature and	itle of certifier	Male	ler	,		icense number	-			ate signed (Mo		
		30. Name and add	ress of person who	completed cause of de	eath (Item	23a) (Type, F	7	IRAS	clin	NON	MY	N1 0207	, 3	5
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22488 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7 150 AM Brooks holas Alousius Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death linton Nursing+ Rehabilitation INTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 ☑ M 2 ☐ F 215 363558 Months Hours Director ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MI linton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2.0735 SA ane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Black If Yes Give 3 ☑ Widowed 4 ☐ Divorced Specify: Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Frank Parsons Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Company TH Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) brooks JOHN SMITH TER the Page 1 and 2 should by the the the Abelth and Mer tant, If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly King daughter Shellford 1 ark Accokee Mi Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Cheltenhan, MD Heltenham Verrans 4 ☐ Donation 5 ☐ Other (Specify) 23/10 21. Signature of Funeral Artice Licensee 420 HST. N.E. 22. Name and Address of Facility 1. Flore Wash, DC, 20002 tuneral HOME 23a. Part Tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STACK DISTEASTE DIALTIS DIFTERDING disease or condition Medical resulting in death) Examiner DEWIFWTA if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner attending physician and for use as the burial-transit DIAMES the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical yprithy Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERIPHERAZ AMISON DISPASSE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No ၉ Other: in 24 hours after deau..
the Funeral Director: After this c 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10065086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
106 LNING STREET, N.W. SUITE WI WASHING WASHING TO DE 20010

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc g905 7-21-10 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month_ 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE 8202 TAMA COURT Social Security Numbe 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD **Funeral** 8. Date of Birth 1 🛛 M 2 🗆 F Months Director 215-28-7290 80 0472471930 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE BALTIMORE MD 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8202 TAMA COURT 21208 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cultan, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No WHITE If Yes, Give Year or Dates. Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) **ATTORNEY** LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MOSES BRODIE GREENFELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA BRODIE / WIFE 8202 TAMA COURT, PIKESVILLE, MD 21208 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State UBAWITZ NUSACH ARI 4 Donation 5 Other (Specify) 07/20/2010 ROSEDALE, MD 21. Sign ture of Funeral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between NCITABITES PHEUMONIA Immediate Cause (Final Onset and Death Filysician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner YEAR DEMENTIA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine YEARS TO 3320) PARKINSON DISEASE attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year 4 Pregnant at time of death 9 Unknown page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 **Z**No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA sing Home 5 🛛 Residence 6 🗌 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined To the Hospital or within 24 hours aff To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 7-19-2010 101 31. Date filed (Month, Day, Year) State Registrar

Physician /Medical Examiner

Physician

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permit. Pages 1 and 2 and 2 and 2 pepartment of Heatth an Important: If item 27 Is any Injury or other trau

Baltimore, Maryland 21215-0036

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Division or Vital Records, P.O. Box 68760,

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Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed Be 25. Was case referred to medical examiner? Other: 4 Shursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral D 🕰 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 375 16,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2835 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	/ Department of Health and I Certificate of Death	Mental Hygiene	010 22491
	Physicia Medi		1. Decedant's Name (First, Middle Last	omwell-No	mell	2. Date of Death Month	3. Time of Death
	Exami		4a. Facility Name (if not institution, gives		4b. City, Town, or Location of Death	4c. Cou	unty of Death
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	and show	ior	Usual Residence of Decedent 10a. State 10b. County	10c_City, To	own or Location		10d. Inside City Limits
	he Maryl or 28a-f notifie	Director	MD Balty 10e. Street and Number	nore Kan	da 1/s town	10g Citizen	1 ☐ Yes 2 ☑ No of What Country?
	ath with sems 23a must be	Funeral	4208 Holbrod	K Road 12. Was Decedent Ever in U.S.	3//33	u	SA
9800	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ठ्व	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify: 	Diegn etc.)	Race - American Indian, Black, White, etc.
21215-(within 72 hou giene. er than "nat er the Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) I EA Cher	ing 16b. Kind o	f Business Industry
Maryland 21215-0036	filed al Hy d oth	To Be	17. Father's Name (First, Middle, Last) Eastern W. F	Payne	18. Mother's Nam	ne (First, Middle, Maiden Suma arct alle	ame)
	and 2 should be Health and Ment em 27 is marke ther traumatic e	8	19a. Informant's Name/Relationship (Typ. Arthur Nower	e, Priti	9b. Mailing Address (Street and Number o		n, State, Zip, Code)
Baltimore,	permit. Page 1 and Department of Heal Important. If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State ceme	e of Disposition (Name of tery, crematory or other place)	Date 20c. Location 3-2010 Ar 11	on - City or Town, State
Bal	permir Depar Impor any in		21. Signature of Funeral Service License	Preme	2. Name and Address of Facility a v. 8728 Libray Rd	Chn C. Greene Randa listour	Mi) 21133
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dec 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ☐ Ectopic pregnancy		Date of delivery Month Day Year
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Divisio	al or Atten s after deat Il Director; ed in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, the building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No farm, street, factory, office	28f. Location (Street and Num City or Town, State)	nber or Rural Route Number,
	the Hospit in 24 hour the Funera	Medical	(Check 2 \(\sum \) Medical Examine	er: On the basis of examination and	e, death occured at the tirne, date and place, an l/or investigation, in my opinion, death occurred at wledge, death occurred at the time, date and place	the time date and place, and a	due to the cauca(e) and manner etated
	Vith vith Con		29b. Signature and title of certifier COLL HONG	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	29c. License number DOD EAM TO	29d. Date sign	ned (Month, Day, Year)
			30. Name and address of person who con	mi, m &	To N Chuly	st, 78 4	ISON MOZIN
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 5:00 A.M Thomas Odell Conley, Sr. July 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death Lutherville Baltimore 126 Lincoln Avenue If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y Months Days Hours Min 228-68-0255 Director 63 Nov. Virginia Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Lutherville Baltimore Maryland 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera USA 21093 126 Lincoln Avenue 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Willett Company Machinist 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Conley Emma Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleo Conley/ Wife Lincoln Avenue Lutherville, Maryland other 126 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **7/23** ም⁴የበ ō cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury Garrison Forest Vet. Cem. Dwings Mills,MD 22. Name and Address of Facilit Chatman-Harris Funeral Home 21. Signature of Junera Service Licer any 240 Reisterstown Rd Baltimore, MD 21215 ance 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician, Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (of as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
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Pe Funeral Director: After the pleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Tyes Investigation
Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) RI

State Registrar

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 19,2010 July 30 p ^M Manasseh Cromartie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) n/a Baltimore 424 N. Denison St | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nov - 2, 1923 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months NC (Country) 239-30-9713 1 M 2 ☐ F 86 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County N/A MD Baltimore Yes 2□No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 424 N. Denison St 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 🔀 No Specify 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Pastor Church 5yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Henry Cromartie Delia Cromartie 19a. Informant's Name/Relationship (Type. Print) Karla Cromartie/Granddaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4108 Flowerton Rd. Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arbutus Memorial Arbutus, MD 1 Burial 2 □ Cremation 3 □ Removal from State 7/24/10 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 21. Sign re Funeral Serviçe Licepsee 2700 Edmondson Ave. Balto., MD 21223 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Hoard 1 mas.

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

attending p

The law requires that the death certificate be executed certificate this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

State Registrar 29b. Signature and title of certifier

Sequentially list conditions, if any, leading to amount cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect to (or a)))).	quency of B	lock		- 9	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of o	al death 3 □Ectopic	c pregnancy (specify)		23d. Date of deliving Month	very Day Year
Part II. Other significant conditions of	contributing to death but not res	sulting in the underlyin	g cause given in Part I.		r	the cause of death? bably 4 □Unknown
				24a. Was an autopsy performed2 1 Yes 2 N	prior to co	opsy findings available ompletion of cause of
25. Was case referred to medical examiner?			26. Place of De	eath <i>Check onl o e</i>		
1 ☐ Yes No	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpatient 3□	DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Spec	ify)
27. Manner of De \ h 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
3 ☐ Suicide 6 ☐ Could not be determined		iome, farm, street, fac	tory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
	nysician: To the best of my knominer: On the basis of examination					

License number

29d. Date signed (Month, Day, Year)

716 Maiden Choice lane, ste 301

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Physician/ 1 9 Day Jacob Reese Chenowith 2010 7:00 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Towson Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Months Days Hours (Month, Day, 219-18-4098 Baltimore, Maryland 88 Yrs. Director August Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shor lury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Towson Maryland Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code Gritien of Wist Country's 21204 Funeral 615 Chestnut Avenue of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Agnes Donnelly John C. Chenowith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4807 Long Green Road Glen Arm, Maryland 21057 Mr. David R. Chenowith/ son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot July 1 Burial 2 Cremation 3 Removal from State Parkville, Maryland Moreland Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signature of Fineral Service License 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ TUBULER MECLOSU Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any heading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part-23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 🖰 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and

31. Date filed (Month, Day,

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

trar's Signature

License number

29d. Date signed (Month, Day, Year)

TONJUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Florence Gordon Cantrell 16 2010 July 3:50 a^M Medical 4a. Facility Name (if not institution, give street and number)

Ednor's Eldery Home 4b. City, Town, or Location of Death
Silver Spring 4c. County of Death
Montgomery **Examiner** 5. Social Security Number 068-07-30 29 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**X** F Months Days Hours Min 93 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Takoma Park 1 X Yes 2 ☐ No 10f. Zip Code 20912 10g. Citizen of What Country? USA 909 Sligo Creek Parkway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Specify Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Registered Nurse Helathcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Julia Palmer ဂ္ဂ Henry H. Gordon II 19a. Informant's Name/Relationship (Type, Print)
Susan Gordon Hurley/
Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 Sligo Creek Parkway, Takoma Park, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Final Journey Crem. 7/17/10 1 Burial 2 Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Signature of Funeral Service LicenseeDorota Marshall Marchal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 4 years Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month hed the 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Osteoporosis, Glaucoma, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed Macular Degeneration 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy this certificate 2X No 1 Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ 2**XX**No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Group Home 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 🗆 No ☐ Accident Investigation 6 Could not be completed filled in by the within 24 hours after deal To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certify/19 Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date pigned (Month, Day, Year)

State Registrar 30. Name and address of p Robert

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Girsberg,

32. Registrar's Signature

J.

cause of death (Item 23a) (Type, Print) berg, M.D. 3905 National Drive #220, Burtonsville, MD

State of Maryland / Department of Health and Mental Hygier 1

22496

				,	Cen	tificate of	Death	F	leg. No.	22470
	Physicia		1. Decedent's Name (First, Middle, La	Daryl H.	Crib	b		2. Date of Dea _Month July	18 ^{Day} 201 ^Y	3. Time of Death 8:00 PM
Ť.	/Medic Examin		4a Facility Name (If not institution, giv Northamptor				4b. City, Town, or L	ocation of Death	4c. County of I	
Ī	Funeral Director		5. Social Security Number 6. S 123-22-3958 1	Sex 7. Age (In yrs. la 1 □ M 2X□ F 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 2/27/	1919 9.	Birthplace (State or Foreign Country)
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State	erick 10c. City,	Town or Loc		Middleto			10d. Inside City Limits 1 ☑XYes 2 ☐ No
	h with the 23a or 28a st be not	Funeral Director	10e. Street and Number 4 Stone Spri	ngs Lane		10f. Zip Code	21769		10g. Citizen of Wha US	
020	urs e	<u>۾</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 IXYes 2 □ No Arm of Yes, Give 1 9 4 2 - 1	3.7	das Decedent of Nas Decedent of Nas Pecify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc. White
0200-91212	d within 72 ho giene. rr then "netur The Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College 41-4or 5+)	(Give k	O NOT use retire	during most of work		16b. Kind of Busin	thcare
/land	ed at b	To Be C	17. Father's Name (First, Middle, Last) George Richa						Maiden Surname) eterson	
Mar	and 2 should ealth and Men n 27 Is marks ler traumatic		19a. Informant's Name/Relationship (Marla D. Leig				and Number or Rui			
Baitimore,	of H of H roth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Fina	al Jou	ition (Name of atory or other pla rney Cre	m. 7	Date 7/21/10	20c. Location - Cit Woodbin	e, MD
Dai	permit. Pag Department Important: If any Injury o once.		21. Signature of Funeral Service Licer	w, llauhall	all 22.	Name and Addre Mary PO B	land Creox 1413	emation Balti	Servic more,	es MD 21203
7	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death.			-			Approximate Interval Between Onset and Death
,	Examiner	er	disease or condition resulting in death)	a. Due to (or		ence of):	you or	L WEST		rontes.
	mecuted and al-transit	xamin	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ence of):				(-1114)
04 08 X	ing enti	Med	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	as a consequ	ence of):				
7.0	the d	Physician	Part II. Other significant conditions of	ontributing to death but not result	ting in the un	derlying cause gi	ven in Part I.		and the same of th	bute to the cause of death? □ Probably 4 1 Unknown
ecords	S S	Completed by						24a. Was a perfor		24b. Were autopsy findings available prior to completion of cause of death?
ב ב	sician: The law certificate has t lirector, page 2 s		25. Was case referred to medical				26. Place of Deal	th /Chack only or		1 ☐ Yes 2 ☐ No
>	ysicia is cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3□ DOA Oti		- NA	ence 6 Other	(Specify)
O HOISIA	Attending Physician: or death. ector: After this certific by the funeral director.		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ryat rk? IYes 2 □ No	28d. Describe h	ow injury occurred	
	al or Atte s efter de il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,
		edical		ysictan. To the best of my know niner: On the basis of examination and manner stated.						
)	Withi Comp	2	29b Signature and title of certifier			29c. Licens	6 222 3		29d. Date signed (#	
			30. Name and advess of person who o	completed cause of death (Item 2)	23a) (Type, P	rint) TTDA	LUE FRE	POEMCE	E MD 2	1702
H	State Registra	е	31. Date filed (Month, Day, Year) ——	32. Pegistrar's Signatu	1 Ba	als				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JMonthy 8:58р м 2040 David Arthur Chaney Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death House Carroll Carroll Hospice Dove Westminster Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1X M 2 □ F Hours Min. Now 15 1947 217-48-9287 Gwatry land 62 Director Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director aryland Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2211 Fridinger Mill Rd. 21157 U.S.A. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Completed by 1 X Yes 2 □ N If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Î971 1 ☐ Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Auto Mechanic Police Dept Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Louise King Broadfoot Robert Earl Chaney permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Fridinger Mill Rd. Westminster, MD. F. Elaine Chaney wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ^{Date} 22,201 July any injury or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All Faiths Crematory 4 Donation 5 Other (Specify) Manchester, MD. Signature of Funeral Service Licenses 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. Haith 3296 Charmil Dr. Manchester, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final STAGE FOOL NOW SMAIL CELL CARRING MADE LUNG Ph_sician/ disease or condition 4 Meals Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending ph IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 1 Yes Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy perforn Hospital or Attending Physician: The Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Norse Practiceer: To the best of my knowledge, death or 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) K. Conton D3161 many (me

Registrar DHMH 17 Rev 7/2009

State

291

BTOBSEL AVENUE WESTMINSTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 HOMAS K. 31. Date filed (Month, Day Mar) 🤰 10-05339 Marybeth Croker Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 22498 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Time of Death Month Medical Examiner 2225 hrs Mary Beth Croker July 16, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funera! Director Months Days Hours Min. 217-76-7013 1/30/1969 1 M 2 X F 41 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Baltimore 1 Yes 2 X No MD Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 5 Ridgemoor Avenue 21221 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces' White, etc. 1 Never Married 2 Married Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: White Specify: ₽ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) within 72 12 Homemaker permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John David Kaehler, Sr. Peitrina M. Lucchesi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peitrina M. Ridolfi / Mother 113 Glenmore Avenue, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 7/20/2010 Baltimore, Maryland Donation 5 Other Specify nature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cocaine Induced Excited Delirium Complicated By **Physician** Approximate Interval Between Onset and /Medical Death Immediate Cause (Final disease a Aortic Incompetence In The Setting Of Police Restraint Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED 1,23a,pt.II,27,28a-f per me g906 8-25-10 vt attending physician or use as the burial X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown Unknown the g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed b should be detac Ś 1 Yes 2 No 3 Probably 4 Unknown Hyperglycemia Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of icate has l page 2 sh performed? death? 1 ✓ Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26. Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other 1 Yes 2 No After t 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Director: 5 Pending 1 Yes 2 X No fd 7-16-10 fd 9:14 p unknown Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Eastern Blvd. & Hawthorne Rd. Middle River, Mc Suicide 6 X Could not be determined founf on street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner 29b. Signature and title of certif. 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 17, 2010 COME 30. Name and address of pe n who completed cause of death (Item 23a) Mary G. Ripple MD **Deputy Chief Medical Examiner** 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ĴŰĽY 18 2010 JACOB CAPLAN 12:45A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7203 ROCKLAND HILLS DRIVE, BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 X M 2 🗆 0472771913 **Director** 219-32-0719 97 Usual Residence of Decedent or 28a-f show 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7203 ROCKLAND DRIVE, #108 21209 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No 3 Nidowed 4 □ Divorced "natural" Completed WHITE Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 6 OWNER FEED other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CAPL AN VICTOR POTTS. MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 ROBERT FELLERMAN / SON-IN-LAW 2417 DIANA ROAD, BALTIMORE, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) RANDALLSTOWN, MD BETH-EL PARK 07/19/2010 In a Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21209 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition CITALO Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if or y, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, • Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burial-transit eled filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ♣ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🖊 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 L. Gertifying Nurse Precitioner T. the best of my knowledge, death original of the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUUNT 31. Date filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygie Pen

		1	For State Registrar	State of Ma	ryland / Dep. <i>Ce</i>	artment of H	ealth and I Death		gie 2 e () ()	22500	
5	1 A S	2)	Decedent's Name (First, Middle, La			2. Date of Dea		3. Time of Death			
	Physici /Medic		Donna Durocher					July	13 201	2 AM	
	Examin								ath		
			Western Maryland Hos 5. Social Security Number 6.		e (In yrs. last birthday	Hagerstown	If Under 24 Hrs.	- 8 Date of Birt	Washington 9.8	rtholace (State or Foreign	
	Funeral Director			1 □ M 2 🖾 F	49 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day Nov 18,	1960 Ma	rthplace (State or Foreign Country) diffic ryland	
			Usual Residence of Decedent							40d Inside City Limite	
	s 1 and 2 should be filed within 72 hours after death with the Maryland Heatih and Mental Hygene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Medical Examinar must be mailled at		10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1X Yes 2 □ No	
		Director	MD Alle	gany	Cumber	10f. Zip Code			10g. Citizen of What (Country?	
		Ö	10e: Street and Number 216 Decatur St	reet; Apt 2	2	21502			USA	,	
Maryland 21215-0036		d by Funeral	11. Marital Status 1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 H If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	Specify:	Specify Yes or No to Rican, etc.)	Black, Wh	hite	
		ete	15. Decedent's E (Specify only highest g	ducation ade completed)	(Giv	edent's Usual Occupa e kind of work done o DO NOT use retired	during most of wo	rking	16b. Kind of Busines	symoust	
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			17. Father's Name (First, Middle, Las				18. Mother's Na	me (First, Middle,	Maiden Sumame) 🛨	mk	
an		To Be	Joseph Michael Ed	kmeyer				Lee Ber			
ary			19a. Informant's Name/Relationship	(Type, Print)					er, City or Town, State		
	and 2 ealth a m 27 is		Leo Durocher -	husband			Street;	Apt 2;	Cumberland	I, MD 21502	
Baltimore,	permit. Pages 1 and Department of Health Important: if item 27 any injury or other ti ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Contro	□Removal from State	/	osition (Name of ematory or other plac	(e)	Date	20c. Location - City	or Town, State	
			21. Signature word Service conseed the Conseed State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201								
4	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Za. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition Approximate Interval Between Onset and Death							Interval Between Onset and Death	
			1	Res	Due to (or as a consequence of): Respiratory failure					one year	
Division of Vital Records, P.O. Box 68760,		Examiner	Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	c. Flaccid Panal Sis Se month to Boulism Due to (or as a consequence of):					one year	
		dicai Exa	resulting in death) Last	c. Flace id Penal Sis Se may to Boulism one year Due to (or as a consequence of): d. Human immunodeficiency /accquired immune deficulty one year Syntheme							
		Completed by Physician/Medi	JE FEMALE			<i>U</i> .	-		654	Mine	
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. Date of Common Month 5 Other (specify) 9 Unknown						delivery Day Year		
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4X Unknown								
			HepaHtis B and Hepatitis C 1 Yes 2 No 3 Protection of the patricular of the surface of the surf						autopsy findings available to completion of cause of 1?		
		e C	25. Was case referred to medical	venbus	Turing	18374	26. Place of Do	1 ☐ Yes eath (Check only	70.0	165 20 140	
		To Be	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpati	ent 2 ER/Outpati	ent 3 DOA Ott	har		idence 6 Other (S	Specify)	
			27. Mapner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?							
		atic	2 ☐ Accident investigat	on	M 1 Yes 2 No				ocation (Street and Number or Rural Route Number,		
		Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 200. Flace of fit				City or To	Town, State)		
		edicai Ce	29a. Certifier (Check only (Ch								
	within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner s	ia idu.	29c. Licens	se number		29d. Date signed (M	onth. Day, Year)	
	F 3 7 8		124	7-	-	D 40	1996		JULY 13	2010	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue								
*		ate	31. Date filed (Month, Day, Year)		rar's Signature	Hage Hage	gerstown,	MD 21742			
	Regist	rar	JUL 212	UIU Keru	w p. A	The state of the s					

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